IDENTIFYING AND WORKING WITH NON-RESPONSIVE AND DETERIORATING PATIENTS WITHIN THE PROCESS OF SUPERVISION: METHODS OF PRACTICING SUPERVISORS

By

Katrina Anne Rast, M.S.

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APPROVED:

Valerie Gifford, Advisory Committee Chair
Eric John David, Committee Member
Charles Geist, Committee Member,
Associate Dean, *College of Liberal Arts*
Cecile Lardon, Committee Member
Jason Whipple, Committee Member
Valerie Gifford, UAF Program Director
Ph.D. Program in Clinical-Community Psychology
James Fitterling, UAA Program Director
Ph.D. Program in Clinical-Community Psychology
Cecile Lardon, Chair, *Department of Psychology*
Todd Sherman, Dean, *College of Liberal Arts*
Helena S. Wisniewski,
Vice Provost for Research and Graduate Studies
Dean of the UAA Graduate School
Michael Castellini, *Dean of the* UAF *Graduate School*

Abstract

Clinical supervision is widely considered to be an essential part of psychotherapy training, encouraging trainee growth, and ensuring the best possible outcome for patients. The use of routine outcome monitoring (ROM) systems in clinical practice has been shown to be beneficial in improving patient outcome within psychotherapy. In addition to its utility in clinical practice, research has suggested that the use of ROM systems and patient feedback within the supervisory process may also have a positive impact on patient outcome. Despite these potential benefits, there is no existing literature about how supervisors identify and work with patients at risk for deterioration within the supervision process. This study aimed to explore the influence on regulatory focus and the use of ROM systems within supervision. Additionally, this study sought to explore two questions: 1) How do supervisors currently identify supervisee patients who are unresponsive to treatment or deteriorating? and 2) How do supervisors currently work with unresponsive or deteriorating patients in supervision? Using a quantitative approach, results suggest that the majority of supervisors rely heavily on clinical judgment in order to identify treatment non-responders and irregularly use ROM systems in order to identify these patients. In addition, the results suggest that the majority of supervisors respond to deteriorating patients in a way that coincides with existing literature pertaining to common practices within psychotherapy. Furthermore, there appears to be a prominent lack of understanding of the purpose and use of ROM systems within supervision. Finally, results indicate that promotion scores are a predictor of the use of ROM within supervision. Implications for research and clinical practices are discussed, in addition to limitations and future directions of the study.

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Introduction

Psychotherapy has been shown to be effective in treating the majority of patients who enter into mental health treatment (Hansen, Lambert & Forman, 2002). However, research has also shown that a significant percentage of individuals fail to benefit from psychotherapy and a smaller percentage of patients have been shown to deteriorate despite treatment (Hansen et al., 2002). Furthermore, research suggests that clinicians, even those with a vast amount of experience, have difficulty identifying deteriorating patients throughout psychotherapy based on their clinical judgment alone (Hannan et al., 2005). This inability to detect deteriorating patients during the course of psychotherapy has resulted in widespread efforts to develop routine outcome monitoring (ROM) systems that can utilize patient feedback to identify and address patient deterioration (Hatfield & Ogles, 2006; Lambert et al., 2003; Whipple & Lambert, 2011).

Empirical investigation of various ROM systems within clinical practice have been shown to have a positive effect on psychotherapy outcome, increasing the likelihood of positive treatment outcome and decreasing the likelihood of patient pre-mature termination (Hatfield & Ogles, 2006; Lambert et al., 2001; Reese, Norsworthy & Rowlands, 2009; Shimokawa, Lambert, & Smart, 2010). Despite the benefits of incorporating ROM systems and patient feedback in the extant literature, there still exist a significant number of clinicians who fail to use such tools (Hatfield & Ogles, 2007). Moreover, it appears that the use of ROM systems and patient feedback may not be being utilized within the training and supervision of novice clinicians (Hatfield & Ogles, 2007).

Clinical supervision has widely been considered to be an essential component of clinical training in psychotherapy (Ellis & Ladany, 1997). Although various supervisory

methods are practiced, within most major models of supervision the primary responsibility of the supervisor is to ensure patient welfare through positive treatment outcome (Falender & Shafranske, 2004). Current literature has found that trainees who received supervision were less likely to have patients pre-maturely terminate and were more likely to have higher rates of satisfaction with psychotherapy (Bambling, King, Raue, Schweitzer, & Lambert, 2006). Additionally, research has shown that when the supervision process notifies trainees of potential negative patient progress, patient outcome is improved (Lambert & Hawkins, 2001).

Due to the combined push within the field to monitor patient treatment progress in evidenced-based practice (American Psychological Association, 2006) and within clinical supervision to ensure a positive treatment outcome, it would seem prudent to identify what factors (e.g. regulatory focus) contribute to the use of outcome monitoring systems within supervision. Additionally, it is important to identify what supervisors are currently doing in supervision to identify patients who are not responding to psychotherapy or are at risk for a poor treatment outcome (Swift et al., 2015; Worthen & Lambert, 2007). The proposed study seeks to examine the influence of regulatory focus on the use of ROM systems within supervision, as well as what methods supervisors are currently utilizing in order to identify psychotherapy non-responders and how supervisors are addressing these patients within the supervisory process.

Chapter 1 Psychotherapy Outcome: The Efficacy and Effectiveness of Psychotherapy

Over the last 70 years, mounting research has continued to show the efficacy and effectiveness of psychotherapy (Duncan, Miller, Wampold, & Hubble, 2010; Norcross & Lambert, 2011; Perry, Banon, & Ianni, 1999; Seligman, 1995). Indeed, studies have shown that psychotherapy tends to positively impact patients, with roughly 60-70% of individuals benefiting from psychotherapy treatment (Hansen, Lambert & Forman, 2002). Numerous studies, which have examined various clinical orientations and techniques, have found psychotherapy to be effective across broad populations, diagnoses, and severity of symptoms (APA, 2012; Duncan et al., 2010; Norcross & Lambert, 2011; Perry et al., 1999). The efficacy of psychotherapy has been shown for various theoretical orientations ranging from behavioral and biological-based models (e.g. Cognitive-Behavioral Therapy) to their more relational counterparts (e.g. Psychodynamic Psychotherapy). Furthermore, meta-analyses of the existing research have shown that all bona fide therapies, when properly utilized, yield the same positive outcome for patients (Duncan et al., 2010; Perry et al., 1999; Seligman, 1995; Smith & Glass, 1977; Wampold et al., 1997).

While the success of psychotherapy treatments cited above within randomized controlled trials (RCTs) has been well established, Minami and colleagues (2007) wished to expand the research by exploring whether or not treatment in routine practice could produce the same outcome results as RCTs. Research conducted in routine practice settings has been difficult to cultivate due to the lack of clinical settings that utilize standardized outcome measures (Minami, Serlin, Wampold, Kircher, & Brown, 2008).

The comparison was accomplished by use of 'benchmarking,' which allows for results from clinical settings to be compared with those of RCTs. The 'benchmarking' strategy is accomplished by calculating pre- and post-treatment effect size estimates within the clinical setting and comparing these against the observed effect size (Minami et al., 2009). Using this method, Minami and colleagues reviewed independent clinical trials on depression that were published between 1995 and 2003 as well as individual studies on depression that were included in meta-analytic reviews in an effort to compare treatment outcome from RCTs and routine clinical practice (Minami et al., 2007). Results indicated there were no significant differences in final outcome between patients treated in RCTs and those of routine clinical practice when using the 'benchmark' approach. Additional studies examining the results of routine clinical practice have also suggested the effectiveness of psychotherapy within these settings (Minami et al., 2007). In summary, the existing literature has consistently shown that psychotherapy generates large treatment effects overall and that there are no differences in outcome for patients treated in RCTs or routine clinical practice.

Identifying Deteriorating Patients Within Psychotherapy

Despite the general effectiveness of therapy within clinical trials and routine practice, there are still a significant percentage of psychotherapy patients who fail to benefit (20-30%) or deteriorate (5-10%) during treatment (Hansen et al., 2002; Lambert & Ogles, 2004). Patients who are unresponsive to psychotherapy or at risk for deteriorating are defined as patients who show increasing distress early in treatment on standardized outcome measures (e.g. OQ-45 or ORS), show high levels of symptom distress that would not be consistent with the amount of time in treatment, or have pre-

maturely terminated (attended fewer than five sessions) (Lambert et al., 2004; Miller, Duncan, Brown, Sparks & Claud, 2004). Consequently, there has been a growing movement within the field to better identify patients who are at risk for deterioration and explore reasons why this might be occurring (Lambert, Hansen, & Harmon, 2010; Probst et al., 2013). Moreover, research has been conducted to examine the perspectives of practicing clinicians regarding their treatment effectiveness with patients and their ability to identify deteriorating patients in an effort to improve patient outcome (Reese et al., 2009; Walfish, McAllister, O'Donnell, & Lambert, 2012).

In one study conducted by Hannan and colleagues (2005), researchers compared a therapist's ability to identify patients at risk for deterioration with an empirical algorithm designed to identify at-risk patients. Within the study, 26 trainees and 22 licensed staff at a university outpatient clinic were asked to identify and predict from their caseloads who of 550 patients would likely deteriorate by the end of treatment (Hannan et al., 2005). Each patient completed a standardized outcome measure at the beginning of each session and their scores were not revealed to their therapists. Clinicians predicted only three of the 550 patients would experience a negative outcome and only one of the three patients predicted to deteriorate actually met criteria for deterioration at the end of treatment. By comparison, patient outcome data indicated that forty patients had deteriorated by the end of treatment. When outcome scores were compared with that of the empirical algorithm designed to predict deterioration over the course of treatment, results showed that the algorithm was able to identify 36 of those who experienced negative outcome prior to end of treatment, though it originally identified 83 patients as likely to have negative outcome (Hannan et al., 2005).

Another study looked to investigate therapists' ability to detect negative change within a patient's course of treatment (Hatfield, McCullough, Frantz & Krieger, 2010). Researchers reviewed 70 chart notes of patients who scored within the clinical range of overall distress on a standardized outcome measures at a university counseling center. The clinicians were responsible for scoring and entering the outcome measure data and scores were listed within the patient chart. Researchers reviewed these notes in order to determine if therapists documented progress, no change, or deterioration of a patient. Results revealed that clinicians were only able to identify 21% of deteriorating patients, with 'symptom worsening' being the most frequently reported signal of deterioration (Hatfield et al., 2010).

Taken together, the above results indicate that most clinicians, even those who are well-trained and more experienced, may have a difficult time identifying patients who are likely to fail to respond to treatment or prematurely terminate (Hatfield et al., 2010). The inability to accurately and consistently identify deteriorating patients has become a focal point of exploration among researchers. Due to research suggesting that clinicians have a difficult time identifying deteriorating patients, the ability to ensure quality assurance for patients who are receiving psychotherapy has been called into question (Hatfield et al., 2010).

Furthermore, research has suggested that patients who experience an early response to psychotherapy experience fewer psychological symptoms and are more likely to maintain gains within therapy after treatment has concluded (Haas, Hill, Lambert, & Morrell, 2002). In one study, Haas and colleagues (2002) administered a standardized outcome measure to participants recruited from a university counseling center in order to

explore whether or not early responders to psychotherapy maintain their treatment gains. The researchers found that early, positive response to psychotherapy was associated with the maintenance of gains made within therapy and overall fewer symptoms of psychological distress. This study suggests that those who experience early gains in therapy are more likely to experience meaningful change, whereas patients who do not experience early response are less likely to maintain or increase gains in treatment. Implications from these results suggest that the identification of early responders, as well as the identification of non-responders, may be a useful tool in the pursuit of improving patient outcome within psychotherapy (Haas et al., 2002). Due to clinicians' inability to accurately identify deteriorating patients and the correlation of early response in psychotherapy to positive outcome, there would appear to be an increasing need for clinicians to monitor patient outcome throughout the course of psychotherapy treatment.

Use of Routine Outcome Monitoring Systems in Psychotherapy

Over the past several years there has been a push within the field to consistently implement accurate and effective methods to track patient outcome and identify deteriorating patients (Hatfield & Ogles, 2006; Lambert et al., 2003; Probst et al., 2013; Reese et al., 2009; Simon, Lambert, Harris, Busath, & Vasquez, 2012; Whipple & Lambert, 2011). Numerous methods have been developed to monitor patient progress and provide feedback in order to enhance patient outcome (Lambert et al, 2002). The examination of outcome for patients is ultimately designed as a way of directing practicing clinicians toward identifying effective treatment options for patients in their care (Hatfield & Ogles, 2007). This monitoring of patient progress and outcome can be accomplished by rationally derived or empirically derived algorithms, which have both

shown to be effective in identifying patients who may experience poor outcome (Lambert et al., 2002).

In a study by Hatfield and Ogles (2006), researchers investigated the influence of verbal patient feedback and formal ROM systems on clinical treatment decisions. A survey and clinical vignette were sent to a random sample of APA-member psychologists. The participants were asked to review the vignette and provide their opinion on patient progress and future treatment decisions regarding the patient. Results indicated that psychologists felt that verbal patient feedback was more influential than information from ROM systems on their clinical decisions, despite the data indicating that both forms of feedback had an equal impact on judgment. Interestingly, data from ROM systems suggesting patient deterioration actually led more psychologists to alter treatment, in comparison with verbal reports of deterioration from the patients. In other words, when ROM systems indicating patient deterioration was presented to clinicians, the chances of altering treatment were greatly increased (Hatfield & Ogles, 2006). Based on this research and the accuracy and efficiency of algorithms which can identify deteriorating patients during a course of treatment, there appears to be practical evidence in moving towards the continuous implementation of ROM systems in routine clinical care. A brief description of the most commonly used ROM systems are presented below.

Outcome Questionnaire System. The Outcome Questionnaire System (OQ System), as an example of a ROM system, attempts to improve psychotherapy outcome by providing therapists with treatment progress information to identify if the treatment being used benefits the individual patient and to guide ongoing treatment for patients who are unresponsive to treatment (Lambert et al., 2001; Whipple et al., 2003). The OQ

system is aimed to provide methods and standardized measures to improve patient outcome within treatment for most psychological disorders (Lambert et al., 2010). The system contains several measures that are designed for both adult and youth populations, with each measure designed to be administered on a weekly basis prior to the beginning of the therapy session (Lambert et al., 2010). The dominant measure within the OQ system is the Outcome Questionnaire-45 (OQ-45), which is an empirically based measure designed to assess patient distress on a weekly basis from the initiation of treatment to the point of termination (Lambert et al., 2004). Use of patient feedback and this outcome measure were "designed as assists for therapists in their psychotherapy practice with the intention that they could function independently of supervision" (Worthen & Lambert, 2007, p. 51). The OQ-45 is administered before each therapy session, and typically takes five to seven minutes for the patient to complete. Its objective is to assess three aspects of a patient's well being: symptom distress, issues within interpersonal relationships, and issues pertaining to social role. These items are scored on a five-point scale with a total range of 0-180, with higher scores indicating higher distress and pathology (Lambert et al., 2004). The OQ-45 has shown to be responsive to short-term change in addition to having satisfactory internal consistency, validity and test-retest reliability (Lambert et al., 2004; Lambert et al., 1996; Vermeersch, Lambert, & Burlingame, 2000).

In the first study of the OQ patient feedback system conducted by Lambert and colleagues (2001), researchers examined 609 patients, with half who were randomly assigned to an experimental feedback group and half assigned to the control, no feedback group. Psychological distress was measured by use of the OQ-45, which provided the therapists with a measure of weekly change. Results of the study indicated that the use of

patient feedback, when provided to therapists, within treatment showed an increased duration of treatment and improved outcome amongst patients who were predicted to be treatment non-responders. Furthermore, therapists who saw patients within the feedback group had fewer sessions when feedback indicated that the patient was improving. Additionally, therapists within the study were surveyed about the usefulness of the OQ-45, with results indicating that therapists tended towards viewing the use of the OQ-45 as valuable to monitoring patient progress (Lambert et al., 2001).

A later meta-analysis of three studies examining OQ patient feedback system conducted by Lambert and colleagues (2003) showed that the use of patient feedback reduced patient deterioration by 4-8%, as well as increased positive outcome among patients. Another meta-analysis of the OQ System conducted in 2010 (Shimokawa et al., 2010), replicated earlier findings and unsurprisingly, showed that the ongoing use of patient feedback and the OQ-45 have been found to significantly improve outcome for psychotherapy patients.

Partners for Change Outcome Management System. The Partners for Change Outcome Management System (PCOMS) is another empirically derived outcome measurement system, which uses the Outcome Rating Scale and Session Rating Scale measures (Miller, Duncan, Sorrell, & Brown, 2004).

The Outcome Rating Scale (ORS) was developed by Miller and Duncan (2000), as a brief alternative to the OQ-45, and takes approximately one minute to administer (Duncan et al., 2004). Like the OQ-45, the ORS asks questions pertaining to three areas of functioning, namely, symptoms distress, interpersonal relationships, and social role. Unlike the OQ-45 however, the ORS does so via a visual equivalent in a set of four

questions. Miller et al. (2003) set out to verify whether or not the ORS was valid and reliable as an alternative outcome measure. Researchers recruited participants from both clinical and non-clinical populations. Participants who were in the clinical sample completed the ORS as part of treatment while the non-clinical group completed four administrations of both the ORS and the OQ-45 over a period of ten days to five weeks. Results of the study showed that the ORS held high internal consistency for the non-clinical participants. Furthermore, the ORS was shown to have moderately strong validity and reliability, suggesting the ORS is a quick and effective tool for monitoring patient outcome (Miller et al., 2003).

The Session Rating Scale (SRS) is a four-item clinical tool designed to measure the process of therapy and the therapeutic alliance by allowing patients to give immediate feedback on the psychotherapy relationship to their therapist. This is accomplished by examining different aspects of the therapeutic relationship such as agreement on the goals of therapy, agreement on the tasks of therapy, the emotional bond between therapist and patient (Duncan et al., 2004). The use of this tool within psychotherapy allows clinicians to monitor the working alliance throughout the course of therapy, and alter treatment as necessary in an effort to address misattunements and ruptures that may take place within the alliance. In an effort to examine the psychometric properties of the SRS, Duncan and colleagues (2004) set out to compare the SRS with pre-existing measures that had previously been shown to have strong reliability and validity (e.g. the Helping Alliance Questionnaire-II, ORS, WAI). Results of the study indicated that the SRS had both strong reliability and validity in comparison with the other measures (Duncan et al., 2004). The

research surrounding the SRS indicates that this treatment tool is a reliable and valid measure in which to monitor process and alliance within psychotherapy.

In a study conducted by Campbell and Hemsley (2009), the validity and reliability of the ORS and the SRS were compared against longer measures already in existence that had been shown to have strong reliability and validity. These existing measures included the OQ-45, WAI, Depression Anxiety Stress Scale-21, Quality of Life Scale, Rosenberg Self-Esteem Scale and the General Self-Efficacy Scale. The measures were administered to patients who had been referred for psychological services within a primary healthcare center. Results suggested both the ORS and the SRS had strong validity and reliability similar to that of the longer measures. The ORS and SRS, though much shorter than their longer counterparts, present reliable and valid measures. Additionally, these measures, given their time-limited administration, can be used as a strong, cost and time-effective alternative to longer ROM systems (Campbell & Hemsley, 2009). Together, use of the ORS and the SRS make up the PCOMS. These self-report instruments can be completed and scored within two minutes, can be administered in both written and oral forms, and have been found to be reliable, valid and cost effective (Miller et al., 2004).

In an effort to examine other measures used in continuous feedback systems, Reese and colleagues (2009) examined the use of PCOMS in their exploration on the use of patient feedback and improved patient outcome. In a similar design to Lambert et al. (2001), researchers randomly assigned individuals to either a feedback group or a no feedback condition in an effort to observe whether or not the use of PCOMS had an impact on patient outcome. Results indicated that individuals in both groups showed statistically significant improvements in pre/post measures, consistent with research that

suggests a majority of individuals benefit from engaging in psychotherapy (Hansen et al., 2002). However, results also indicated that patients who used PCOMS experienced statistically significant gains in treatment in comparison to the no feedback group. Likewise, patients within the feedback group who were identified as potential treatment non-responders early within treatment showed greater gains than those who were in the no feedback group. Furthermore, patients who used PCOMS were more likely to experience significant, reliable change in fewer sessions in comparison to the control group (Reese et al., 2009). The overall results of this study were consistent with previous research regarding the use of ROM systems, which suggests that using continuous outcome measures leads to better treatment outcome for patients who are non-responsive early on in treatment (Hansen et al., 2002).

Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM). The Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM) is a standardized outcome measure that was developed in the United Kingdom to be implemented within routine clinical practice (Evans et al., 2000). The self-report questionnaire, which consists of thirty-four items, measures change of patients by monitoring well-being, problems, systems, function, and risk (Evans et al., 2002). Studies conducted by Evans and colleagues have shown that the CORE-OM is a reliable and valid tool that can be used to track patient outcome throughout the process of psychotherapy and is easily implemented into clinical settings.

Barkham and colleagues (2005) sought to explore the utility and appropriateness of the use of the CORE-OM for assessing severity of psychological symptoms within psychotherapy and secondary care settings (e.g. mental health institutions). Data was

collected from thirty-two primary care settings and seventeen secondary care settings. 5,733 patients within the primary care setting and 1,918 patients within the secondary care setting were asked to complete the CORE-OM. Data was then analyzed with results indicating that the use of the CORE-OM was suitable for use in both primary and secondary clinical settings. Additionally, researchers found that though intake scores were similar, secondary care setting patients were more likely to score as higher risk or severe on the CORE-OM. Researchers were able to logically explain this difference as due to individuals within secondary care settings experiencing a longer duration of symptoms than those in primary settings. Despite this difference, the results of the study indicated that the use of the CORE-OM is an appropriate and useful tool in measuring outcome within primary and secondary care settings (Barkham, Gilbert, Connell, Marshall, & Twigg, 2005).

Integra/COMPASS Tracking Assessment System. The Integra/COMPASS tracking assessment system is an outcome measure designed to track patient change in psychotherapy (Lueger, 2012). Change is categorized within three distinct phases, consisting of a remoralized phase, a remission phase, and a rehabilitated phase. This ROM system evolved into a sixty three-item measure designed for use within primary care settings. The Integra/COMPASS measure assesses for subjective wellbeing, anxiety, depression, somatic symptoms, obsessive-compulsive disorder, difficulties with adjustment, and posttraumatic stress. It also includes items assessing for disabilities with daily living, including self-development and social, intimate, and work relationships (Lueger, 2012).

The use of the Integra/COMPASS system has been shown to be reliable and valid within clinical settings. Furthermore, 63% of patients showing patterns of change throughout the process of psychotherapy and 43% of patients show a pattern of symptom remission (Lueger, 2012). The aforementioned success of this ROM system within routine practice, along with its statistical validity and reliability suggests that the Integra/COMPASS system is an acceptable ROM system for use in clinical settings.

Counseling Center Assessment of Psychological Symptoms (CCAPS). The Counseling Center Assessment of Psychological Symptoms (CCAPS) is a ROM system created to fit the needs of college counseling centers. The measure was designed to be a brief, multi-dimensional measure suitable for routine use with college students, with the ability to monitor psychological symptoms as well as assess change throughout psychotherapy (Locke et al., 2012). The CCAPS system, which consists of the CCAPS-62 and its short form, the CCAPS-34, have also been shown to be statistically reliable and valid, and is readily integrated into university counseling centers across the United States (Locke et al., 2011). Furthermore, the CCAPS assesses for features that are typically seen within college populations, but are not often accounted for in other outcome systems, such as binge drinking, issues with body image, eating issues, and mood fluctuations (Locke et al., 2011). In addition to the aforementioned features, the CCAPS-62 also assesses for eight subscales, including depression, eating concerns, substance use, generalized anxiety, academic distress, social anxiety, and family distress (McAleavey et al., 2012).

Empirical Support for Routine Outcome Monitoring

In a meta-analysis conducted by Knaup and colleagues (2009), the evidence of support for the positive effects of patient feedback and outcome management is promising (Knaup, Koesters, Schoefer, Becker, & Puschner, 2009). Twelve publications regarding patient feedback and ROM systems were included within their study, with a majority occurring in outpatient treatment settings within the UK and USA. A review and analysis of the literature suggested small, but significant positive effect on treatment with the use of feedback and outcome management, furthering support for continued research into the use of feedback and ROM systems within clinical practice (Knaup et al., 2009).

In a meta-analytic review of the literature, Lambert and Shimokawa (2011) examined studies that utilized the PCOMS and the OQ-45 to monitor patient outcomes. Researchers found that the systematic use of either of these formal outcome assessments increased patient satisfaction with the therapeutic relationship and accurately detected patient deterioration. The study also suggested that the number of patients who deteriorate during psychotherapy could be reduced by half with the implementation of ROM systems in the feedback process (Lambert & Shimokawa, 2011).

The expansive research on the use of ROM systems and their positive impact on patient outcome suggest that the use of these methods in tracking patient outcome should be implemented in routine practice by clinicians. Although ROM systems are not the only source of information that clinicians use when making decisions about psychotherapy treatment, they can provide information that may be helpful for therapists in measuring patient change (Hatfield & Ogles, 2007). Given that multiple research studies have suggested that the use of ROM systems has been beneficial in identifying and responding

to patients who are unresponsive to treatment, it would seem common sense for clinicians to begin implementing these systems within routine practice.

In a study conducted by Goldberg and colleagues (2016), researchers set out to examine whether improved outcome could be linked to therapist experience. Data on therapists in practice was retrieved from a treatment research archive, which was collected over the course of eighteen years. Patients had completed the OQ-45 prior to each therapy session, which was used to measure treatment progress. Analysis of the data indicated that while patients generally experience positive outcome as a result of therapy, the treatment effectiveness of therapists did not improve with time or experience. In fact, the results indicated that therapists, on average, become less effective over time, with very few becoming more effective over time (Goldberg et al., 2016). Amidst this finding, the researchers speculate that patient feedback may be a crucial component for increasing treatment effectiveness within psychotherapy, pushing clinicians to challenge themselves beyond their current level of competency and encouraging reflective practice in order to address decreased levels of effectiveness. This reflective practice may be beneficial in pushing for the utilization of patient feedback and ROM systems in monitoring patient progress within psychotherapy. The implementation of these tools may help therapist identify and address issues with deteriorating patients, ultimately improving the effectiveness of psychotherapy. Furthermore, the use of outcome systems within the process of supervision may be necessary to increase supervisee self-awareness, and ensure that supervision has a positive impact on patient outcome (Stedmon & Dallos, 2009).

Chapter 2 Routine Outcome Monitoring in Clinical Supervision

Since its emergence as a specialty in World War I, the practice of clinical supervision has widely been considered to be a necessary element of psychotherapy training (Bernard & Goodyear, 2014; Hess, Hess, & Hess, 2008). In fact, it had been widely accepted that clinicians at all points in training benefit from the regular practice of receiving supervision (Falender & Shafranske, 2004). Though psychotherapy has deviated into diverse systems over the past several decades, the clinical supervision of supervisees has remained a central component of training within all supervisory approaches (Falender & Shafranske, 2004; Lambert & Ogles, 1997). Despite psychotherapy's various orientations, tasks, and techniques, the definition of clinical supervision appears to remain consistent throughout systems, sharing common key elements of the supervisory process. One definition of clinical supervision is described as:

> a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues….The objectives of supervision are "normative" (e.g. case management and quality control issues), "restorative" (e.g. encouraging emotional experiencing and processing) and "formative" (e.g. maintaining and facilitating supervisees' competence, capability and general effectiveness). (Milne, 2009, p.15)

Clinical Supervision

Clinical supervision is "considered to be important in learning to function effectively as a psychotherapist and is a role that many view as highly relevant to both

their professional practice and professional identity" (Watkins, 1997, p. 3). According to the *Handbook of Psychotherapy Supervision* (Watkins, 1997), there are six crucial components of psychotherapy supervision: the supervisory relationship, evaluation of skills, the idea that supervision occurs over a period of time, enhances professional functioning, monitors the quality of professional services, and serves as a gatekeeper in regard to entering the field. These elements of supervision serve to aid the supervisee in their growth as a practicing professional within the field, as well as protect patients from inadequate care within treatment. These components are widely considered to be essential to psychotherapy supervision and supervisors are relied on heavily to maintain awareness of them throughout the supervision process (Watkins, 1997).

Models of supervision. Under the umbrella of clinical supervision exist separate supervisory models, each derived from practical and theoretical conceptualizations to aid in the training of supervisees. The five most common supervision models will be briefly explained here. The Developmental model describes the process of supervision in a series of stages, wherein the supervisor initially provides higher levels of direction and support (Stoltenberg, 1981). As the supervisee develops competency over time, the supervisor decreases the amount of direct feedback, with the ultimate goal of this model being that the supervisee becomes more independent and effective at identifying issues (Pearson, 2001). The Technical/Didactic model offers a systematic approach to clinical supervision, by way of providing direct feedback and knowledge of the subject area to supervisees, helping trainees enhance their clinical skills (Falender et al., 2004). The Integrated model of supervision combines the role of teacher, therapist, and consultant when working with supervisees (Bernard & Goodyear, 2014). This model works to develop and promote skill

building with supervisees, highlighting areas such as the therapeutic process and case conceptualization (Bernard and Goodyear, 2014). In the Orientation-Specific model, supervisors engage in supervision through their own theoretical treatment orientation. Some major theoretical orientations include; Behavioral, Cognitive, Cognitive-Behavioral, Humanistic, Integrative/Holistic/Eclectic, Process/Experiential, and Psychoanalysis/Psychodynamic. The use of this supervision model draws in core concepts from each orientation into the supervision process (Bernard & Goodyear, 2014). For example, a psychoanalytic/psychodynamic style of supervision may incorporate the use of transference/countertransference, defense mechanisms, and affective responses within the supervisory process. Likewise, a cognitive-behavioral style may utilize techniques such as setting an agenda for supervision sessions, assigning homework for the supervisee and linking previous sessions into the current agenda (Watkins, 1997). Finally, the reflective model of supervision strives to help supervisees reflect on their current practices through greater self-awareness and evolution of personal and professional identity by means of guiding supervisees through a reflective process in their decision-making (Ward & House, 1998). Each of the above models, though differing in design and structure, strive to enhance supervisees' knowledge and clinical work throughout the process of supervision (Bernard & Goodyear, 2014; Falender et al., 2004; Pearson, 2001; Stoltenberg, 1981; Ward & House, 1998).

Despite the differences that exist between the models of clinical supervision, the core goals of supervision remain consistent, namely, addressing the needs of the supervisee and ensuring positive patient outcome. In general, accountability has become an increasing issue among practicing clinicians (Fireman, 2002). Within the role of

supervisor, licensed clinicians have the momentous task of ensuring patient welfare, as well as addressing the goals and needs of the supervisee whom they are supervising. A review of the literature conducted by Wheeler and Richards (2007) suggests that supervision is most impactful to supervisees, allowing for the development and growth of their professional identity, with the greatest impact on supervisee self-awareness, self-efficacy, and theoretical orientation. Additionally, supervision is considered to be the cornerstone of advancing the professional development of the supervisee (Wheeler & Richards, 2007). The effort to identify and respond to patients often requires a level of self-awareness and reflective contemplation on part of the clinician that takes time and training to develop (Bager-Charleson, 2010). This type of reflective practice within psychotherapy encourages clinicians to be mindful of their impact on the patient, increasing self-awareness and developing professional identity (Kilminster & Jolly, 2000; Stedmon & Dallos, 2009). Although supervision models and practices can be beneficial to supervisees, the ultimate aim is to serve the patient, attempting to ensure that each patient benefits from therapy, reducing the risk of deterioration, and moving towards positive treatment outcome (Stedmon & Dallos, 2009).

According to most major models of supervision, the primary responsibility of the supervisor is to ensure patient welfare by means of positive outcome in treatment (Ellis & Ladany, 1997). Falender and Shafranske (2004) in their competency-based model of supervision stated, "The most important task of the supervisor is to monitor the supervisee's conduct to ensure the best possible clinical outcome for the patient" (p.4). As noted by O'Donovan, Halford and Walters (2011), if the primary purpose of

supervision is to ensure the positive outcome of patients, supervision must find a way to guarantee that supervisees can provide safe and effective treatment for patients.

Many of the educational and training elements of psychotherapy are facilitated through supervisor feedback during the supervision process. In fact, according to Goodyear and Bernard (1998), one of the key components of supervision is the feedback given by a supervisor to a supervisee. A qualitative study conducted by Hoffman and colleagues (2005) explored the practice of giving feedback to supervisees during supervision, looking to investigate the process of giving easy, difficult or no feedback to supervisees. Interviews relating to feedback within supervision were conducted with fifteen counseling center supervisors. Results indicated that feedback was most easily provided when given directly, was prompted by the supervisee, and pertained to clinical issues. Difficult or no feedback, often about personal, clinical, or professional skills, was not provided directly and was not facilitated by the supervisee, suggesting that feedback within supervision is most easily given when the supervisee is open and engaging in reflective practice (Hoffman, Hill, Holmes, & Freitas, 2005).

Clinical supervision and research. Though models and methods of psychotherapy can vary, research suggests that supervisors and supervisees agree that that the practice of clinical supervision is an important element of clinical psychology training (O'Donovan et al., 2011). Additionally, current research shows that both supervisors and supervisees believe that clinical supervision is both beneficial and important in impacting supervisee patient outcome (Rast, Herman, Rousmaniere, Swift, & Whipple, 2017). To that end, it would appear crucial to monitor supervisee patient outcome in order to ensure

effective treatment and positive outcome given the difficulty therapists have identifying psychotherapy non-responders and deteriorators.

Worthen and Lambert (2007), further explored this issue within an article arguing for the increased use of ROM systems within supervision. Researchers reiterated that regularly monitoring outcome by use of formal methods could enhance patient outcomes. Moreover, using formal assessment to monitor patient outcome can enhance patient outcome, as well as provide a more focused supervision experience (Worthen & Lambert, 2007). Other researchers have echoed this stance, offering up strategies and techniques for incorporating patient feedback into the supervisory process (Swift et al., 2015). Despite the general perception of the importance of supervision in both clinical training and impacting patient outcome, there are no studies that show how supervisors are tracking the outcome of their supervisees' patients. Furthermore, there is little research showing how supervisors address supervisee patients who do not appear to be responding to therapy.

Bambling et al. (2006), after extensive reviews of the literature, determined that a significant portion of research on trainees has predominantly focused on the process of supervision, disregarding the impact of supervision on patient outcome as well as trainees' competence. The negligence of research in this area makes it difficult to establish if supervision has any significant impact on outcome, despite studies that indicate both supervisors and supervisees believe that supervision can and should have an impact on patient outcome (Rast et al., 2017). There is a small body of literature that suggests trainees who received supervision were less likely to have patients pre-maturely terminate and were more likely to have higher satisfaction with therapy (Bambling et al.,

2006). Furthermore, studies have shown that when supervision notifies trainees of potential negative patient progress, patient outcome are improved (Lambert, Hansen, & Finch, 2001). These results suggest that certain aspects of supervision can be beneficial in impacting patient outcome. It would seem probable that the use of ROM systems would be beneficial within the context of supervision, possibly monitoring trainee competency as well as focusing efforts toward improving patient outcome (Lambert & Hawkins, 2001).

In a study conducted by Reese and colleagues (2009), researchers examined whether or not providing supervisors with patient feedback from their trainee's patients would impact patient outcome. Twenty-eight trainees were assigned to either a feedback group or a non-feedback group over the course of one year. Results indicated that while patients in both groups showed better outcomes, the patients within the feedback group were shown to have more improvement, with treatment being twice as effective within the feedback condition in comparison with no feedback. Additionally, researchers monitored any impact on the supervisory relationship throughout the study and found that the use of patient feedback did not improve the supervisory relationship, nor did it increase satisfaction with supervision. The results of this study suggest that while patient feedback has less influence on the supervisory relationship, the feedback may be more helpful in helping trainees assess their clinical skills, allowing for the improvement of clinical skills, which may ultimately benefit patient outcome (Reese et al., 2009). This research, which is currently the only existing study on this topic, provides favorable evidence for the use of ROM systems within supervision.

Regulatory focus theory. One possible reason that supervisors may or may not use ROM systems within their supervisory practices may be related to regulatory focus theory. According to regulatory focus theory, individuals tend to seek out pleasure and avoid painful experiences and this is seen as having an important impact on the achievement of individual goals (Higgins, 1997). Higgins (1997) differentiates between two systems based on meeting these goals, known as promotion and prevention systems. Individuals who have strong motivation in achieving success are seen to have promotion focus. Those who tend toward a promotion focus are more oriented on winning and concentrate primarily on fulfilling personal standards. By contrast, individuals who have a strong motivation to avoid failures are seen to have a prevention focus. Individuals who tend toward the prevention focus attempt to avoid failure by being more thorough and vigilant in their actions (Higgins, 1997). For prevention-focused individuals, satisfying the needs and expectations of others is a primary concern. Additionally, Higgins (1997) suggests that it is not only individual characteristics but also situational factors that shape the regulatory focus. In situations where the individual can profit, individuals tend toward the promotional focus, while in situations where failure needs to be avoided the prevention focus is the inclination (Higgins, 1997, 1998).

In a study conducted by De Jong and De Goede (2015), researchers examined therapists and their motivation to achieve success (promotion) or avoid failure (prevention). Results indicated that therapists who had stronger motivation to prevent failures had a more positive outlook on the use of patient feedback during psychotherapy. In terms of monitoring patient outcome, it would seem that prevention focused individuals may be more open to receiving feedback and using ROM systems to monitor

patient outcome throughout the course of psychotherapy treatment. Likewise, supervisors may experience these same phenomena in regard to using ROM systems within the practice of supervision.

Despite little existing research that examines the use of ROM systems as a tool within supervision, numerous researchers have begun to make the case for using outcome monitoring and continuous patient feedback within the supervisory process (Lambert & Hawkins, 2001; O'Donovan et al., 2011; Swift et al., 2015). The current trend in training practices of psychotherapy, in addition to the current efficacy and effectiveness literature suggest two crucial points:

1) The practice of supervision will remain a crucial component of clinical training

2) Patient non-responsiveness and deterioration in treatment are unavoidable phenomena within psychotherapy.

As a result, it would seem that supervisors have the capabilities to prevent possible premature termination if they are able to facilitate the process of identifying non-responders. It is still unclear how supervisors are actually identifying patient deterioration in supervision. With the push toward implementing patient outcome monitoring in the supervision process, further research is needed to examine how supervisors are currently identifying patients who are at risk for deterioration, as well as their current methods for addressing these patients within the supervisory process.

Chapter 3 The Present Study

As mentioned in the introduction, approximately 60-70% of patients benefit from entering into psychotherapy treatment (Hansen et al., 2002). Though numerous studies have shown treatment efficacy and effectiveness of psychotherapy treatment for a majority of patients, there still remain 5-10% of patients who fail to benefit from treatment (Hansen et al., 2002). There has been increasing effort within the field to better identify patients at risk for deterioration as well as explore reasons why deterioration may be occurring (Lambert et al., 2010; Probst et al., 2013). Research has shown that even well trained and experienced clinicians have difficulty identifying deteriorating patients within the course of psychotherapy (Walfish et al., 2012). This failure to accurately and consistently identify deteriorating patients by practicing clinicians has led to the development of ROM systems, designed to be implemented within routine clinical practice (Hatfield & Ogles, 2006; Lambert et al., 2003; Probst et al, 2013; Reese et al., 2009; Whipple & Lambert, 2011). For the purpose of this study, the use of ROM systems is defined as the active monitoring of patient psychotherapy progress in routine clinical practice with standardized outcome measures. Furthermore, its utilization within clinical supervision could enhance patient treatment outcomes, as well as provide a more focused supervision experience (Worthen & Lambert, 2007). Due to the push within the field to implement the use of ROM systems in routine practice and clinical supervision to track patient progress, it is now necessary to identify what supervisors are currently doing within supervision to identify patients who are at risk for poor outcome. The purpose of this study was to examine what methods supervisors are currently utilizing in order to

identify and work with deteriorating patients within supervision. This study aimed to answer three questions:

1) How do supervisors currently identify supervisee's patients who are unresponsive to treatment or deteriorating within the process of supervision?

2) How do supervisors currently work with unresponsive or deteriorating patients within supervision?

3) Does the supervisor's regulatory focus impact the use or non-use of ROM within supervision?

An exploratory survey regarding these three questions helped us better understand the current practices of supervisors and how regulatory focus impacts use of ROM systems within supervision. Furthermore, this study helped us better understand how supervisors identify and address deteriorating patients within supervision with their supervisees. For the purpose of this research, supervision is defined as "a relationship between two or more people whose purpose is the development of the supervisee as a professional psychotherapist" (Watkins, 1997, p.508). Additionally, patients who are at risk for poor outcome are defined as patients who show significant distress on standardized outcome measures (e.g. OQ-45 or ORS), show high levels of symptom distress that would not be consistent with time in treatment or have pre-maturely terminated (attended fewer than five sessions) (Lambert et al., 2004; Miller et al., 2004).

Open-ended questions (discussed below) furthered our understanding of how supervisors identify and work with non-responding and deteriorating patients within supervision. Due to the exploratory nature of this research, this study aimed primarily to collect as much pertinent information as possible as it relates to the current research

questions. This includes examining the relationship between primary placement and supervisor characteristics, despite not being a primary purpose of the study. This was completed due to the limited literature that currently exists within the field of supervision and serves the purpose of adding to current literature. The hypotheses for this study were designed based on existing literature that explored therapists' use of ROM systems (Hatfield & Ogles, 2007). Hypotheses for statistical analyses are as follows:

1) On average, clinical supervisors are not utilizing ROM systems as part of clinical supervision practices to identify non-responders.

2) On average, supervisors who are more inclined toward a prevention focus on the 'Regulatory Focus Scale' will be more likely to use ROM within supervision.

3) On average, supervisors who used ROM systems or received graduate/post graduate training in ROM systems will be more likely to use ROM within supervision.

4) On average, supervisors who did not use or receive graduate/post-graduate training in ROM systems will be less likely to use ROM within supervision.

5) On average, of supervisors who do utilize ROM within supervision, the format of supervision (audio/video recording, case review, live supervision) will not reveal any statistically significant differences.

6) On average, within the group of supervisors who do not utilize ROM in supervision, format of supervision (audio/video recording, case review, live supervision) will not reveal any statistically significant differences.

7) Other variables (age, gender, ethnicity, etc.) will have no statistically significant correlation with the use/lack of use of ROM systems in supervision.

Chapter 4 Methods

Recruitment

This study aimed to recruit mental health supervisors who are currently supervising at least one trainee. As such, inclusion criteria included being a practicing supervisor within the field of mental health who is currently supervising at least one trainee, regardless of supervisory experience. Exclusion criteria included participants who are not currently practicing supervision with at least one trainee within the field of mental health. Prior to data collection, a dichotomous endpoint, two independent sample study power analysis was conducted in order to determine an appropriate sample size. Based upon the results of this analysis, the study aimed to collect data from a minimum of 180 practicing supervisors.

Data Collection

A confidential, web-based survey (Surveymonkey.com) was utilized to collect data for this study. Additionally, the use of snowball sampling was utilized (Singleton & Strait, 2010). The use of surveys as a method of data collection has been well documented within the field of psychology and social sciences (Krosnick, 1999). Online surveys have been shown to be effective in collecting data from a wide and unique range of participants, allowing for access to participants who share specific interests and professions (e.g. practicing psychotherapists who currently engage in supervision practices) (Wright, 2005). After approval from the University of Alaska, Fairbanks (UAF) Institutional Review Board (IRB) (IRB#893787-1), an e-mail was sent out through list-servs to solicit participants who practice psychotherapy and are currently practicing supervisors (e.g. American Psychological Association Society of Counseling

Psychology, American Psychological Association Society for the Advancement of Psychotherapy, etc.). These list-servs were chosen due to a focus on the phenomena as it occurs on a national level and the likelihood of their members being practitioners of psychotherapy and providing clinical supervision. Approximately 600 e-mails were also sent to individuals who indicated that they practiced psychotherapy through the website www.psychologytoday.com. Though there was no way of knowing whether these individuals provided supervision, the survey was sent and a request to forward the e-mail to individuals who did practice supervision was included. The option to complete the survey was voluntary and took approximately twenty minutes for the supervisor to complete. There was no monetary gain for individuals completing the survey. Additionally, there was no penalty for those who did not wish to complete the survey. This survey was created by the author due to necessity, as presently there is limited research within this area of study and are currently, to the best of this author's knowledge, no previously existing studies examining how practicing supervisors identify deteriorating patients within supervision. Furthermore, there is currently no existing research exploring how supervisors address deteriorating patients within the process of supervision.

Study Design

Quantitative methods. The goal of the survey research design is to gain an accurate depiction of the population, which is being examined (Gravetter & Forzano, 2012). Due to the exploratory nature of this research, a web-based survey was utilized, along with open-ended questions, in order to answer the proposed research questions. A web-based survey was decided upon due to its ability to obtain a large sample size, as

well as its ability to obtain more diverse samples in comparison with traditional methods (Gosling, Vazire, Srivastava, & John, 2004). Furthermore, research suggests that web-based results are consistent with results obtained from more traditional methods (Gosling et al., 2004). This study applied descriptive survey methodology, which consisted of questions regarding demographic information as well as questions rated on a 4-point Likert scale regarding how supervisors identify deteriorating patients within supervision. A 4-point Likert scale was decided upon based on existing literature related to item response theory, which suggests that the use of 4-point scales produces accurate results for categorical data (e.g. Likert-type scales) using item factor analysis (Asun, Rdz-Navarro, & Alvarado, 2016). The use of quantitative methodology was decided upon due to its ability to obtain large and diverse samples in order to explore values, opinions, and behaviors. (Singleton & Straits, 2010).

Measures

Basic demographic information. Participants were asked to answer questions regarding their gender, age, and ethnicity. Continuous variables were decided upon as using continuous data can provide valid analysis and can be conducted with smaller samples, as well as higher sensitivity to changes within the data set. Basic demographic information is a general element within empirical studies in order to describe populations who are being targeted within the research. Furthermore, it is also used for the comparison of subsets within the sample as it pertains to demographic categories.

Supervisor characteristics. Participants were asked to answer questions regarding their training background, systemic influences and methods of practicing supervision. These items are included based on existing literature that may suggest that

characteristics of therapists may influence the use or non-use of ROM systems within everyday practice. These therapist characteristics may extend to supervisor characteristics, which may also influence the use or non-use of ROM systems within supervision.

Training background. Participants were asked to answer questions regarding their highest degree earned, their use of ROM systems in graduate and post-graduate training, their training in ROM systems in graduate and post-graduate training, theoretical orientation, and the number of: completed supervision courses, years since they've completed graduate school, years practicing psychotherapy, and years practicing supervision.

Methods of supervision. Participants were asked questions regarding their model of supervision, the primary format of supervision, average number of hours spent supervising a single supervisee, and the number of supervisees they are currently supervising.

Environmental influences. Participants were asked to answer a question regarding their primary placement of employment.

Regulatory focus scale (RFS). The RFS was developed as a 10-item instrument to identify promotion-focused and prevention-focused individuals as it relates to regulatory focus theory (Fellner, Holler, Kirchler, & Schabmann, 2007; Higgins, 1997). The aim of the development of the RFS was to be able to generally identify promotion-focused and prevention-focused individuals without being restrictive to any exact population (Fellner et al., 2007). The measure characterizes the security and growth needs of the individual, identifies the pursuit of personal goals as well as the satisfying of

other's expectations. These items are rated using a 7-point scale ranging from "definitely untrue" to "definitely true" (Fellner et al., 2007). To determine the regulatory focus inclination of the participants, a solitary promotion score was calculated from the five promotion items, likewise a solitary prevention score was calculated from the five prevention items. Participants whose promotion score lay above the median and whose prevention score lay below the median were included within the promotion category. Those with a promotion score that lay below the median and prevention score that lay above the median were included within the prevention category. All other participants were categorized as indifferent (Fellner et al., 2007). This measure was chosen based on existing literature that therapists who are prevention-focused may be more inclined to incorporate patient feedback into their practice (De Jong & De Goede, 2015). This may extend to supervisors and the use of ROM systems within supervision.

How supervisors identify non-responsive and deteriorating patients in supervision. The questions that aimed to answer "How do supervisors currently identify supervisee patients who are unresponsive to treatment or deteriorating?" were designed and modeled off of existing literature suggesting common methods for identifying at risk or deteriorating patients in psychotherapy. This includes: ROM systems (Lambert et al., 2002; Miller et al., 2004), verbal feedback from patient (Hatfield & Ogles, 2006), and clinical judgment (Lambert et al., 2002). An open-ended question was provided for other responses. Additionally, the survey included questions rated on a four–point Likert scale on how supervisors work with deteriorating patients within the supervision process. These items were included in order to collect data regarding the frequency of methods

used in how supervisors currently identify non-responsive and deteriorating patients within supervision.

How supervisors currently work with non-responsive and deteriorating patients in supervision. The survey questions that aimed to answer "How do supervisors currently work with unresponsive or deteriorating patients within supervision?" were designed and modeled off of existing literature that demonstrates various methods and techniques that have been shown to have positive impact on patient outcome. This included: focus on common factors (goals, tasks, bond) (Hofmann & Barlow, 2014), attendance to the therapeutic relationship (Orlinsky, Grawe, & Parks, 1994), attendance to the therapeutic alliance (Norcross & Wampold, 2011), focus on social support and social networks (Duncan et al., 2004; Roehrle & Strouse, 2008), focus on supportive approach (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983) and altering treatment methods (Whipple et al., 2003). An open-ended question was provided for other responses. These items, which were rated on a four-point Likert scale, were included in order to determine the frequency of methods used regarding how supervisors currently work with non-responsive and deteriorating patients within supervision.

Open-ended statements. Phenomenological analysis was conducted in order to explore the open-ended questions in an effort to further explore the research questions. The use of phenomenology is a design that best fits studies in which there is little or no research within the literature (Finlay, 2009). Due to the fact that this study is exploratory in nature, phenomenological analysis was considered the best 'fit' for this method of research. Phenomenology attempts to capture an individual's lived experience and as such, open-ended questions were utilized in an attempt to encapsulate participants'

subjective experience (Atwood & Stolorow, 1993). Phenomenology is best described as interpretive, as opposed to deductive. In this regard, it sought to illuminate the subjective experience of the participant, with no concern for hypothesis testing, controlling for variables, or statistical significance (Creswell, 2012). In this way, phenomenology encourages participants to share the full range of their experience, which may uncover new themes and conceptualizations of the topic at hand (Finlay, 2009). The open-ended questions provided allowed participants to elaborate and share their full subjective experience of the questions, allowing for a more "in depth" understanding of their perceptions of the subject matter. The open-ended statements are as follows:

1) Please describe how you identify treatment non-responders and deteriorating patients within supervision.
2) Please describe what interventions you use to work with patients who are non-responders and deteriorating patients within supervision.
3) What is your current understanding of the use of routine outcome measures within supervision?
4) What are the strengths and weaknesses you see when using routine outcome measures within supervision?

Analyses

Quantitative analysis. Once the data was collected, a series of descriptive analyses was conducted (Pagano, 2001). These analyses were completed using Statistical Package for the Social Sciences (SPSS) software. Statistical significance was set at $p < .05$. 95% confidence intervals were calculated. Due to the exploratory nature of this study, univariate analyses (means and standard deviations) were first calculated in an

effort to determine averages among the sample (Warner, 2013). The examination of correlations (Pearson's r) were utilized to measure the strength of correlations between variables within the data (Warner, 2013). Any existing correlations between groups of those who use ROM systems and those who did not use ROM systems were examined in an effort to better understand supervisory practices. Effect sizes were calculated at .10 (small), .30 (medium) and .50 (large), as suggested by Cohen (1992). Cohen's power analysis for correlations suggests a sample size of N = 85 (Cohen, 1992). Additionally, one-way analysis of variance (ANOVA) were utilized to compare means between groups (Warner, 2013). Analyses using ANOVA helped this researcher determine any statistical differences between group means within the quantitative data (Warner, 2013). Due to the number of analyses, family-wise error rate was used to adjust the alpha (Warner, 2013). A detailed description of the use of family-wise error rate is included in the following section. The hypotheses and specific analyses that were conducted are as follows:

Hypothesis 1. The first hypothesis stated, "On average, clinical supervisors are not utilizing ROM systems as part of clinical supervision practices to identify non-responders." Means and Standard Deviations were calculated in order to determine the average amount of ROM use or non-use within the sample. One-way ANOVAs and chi-square tests of association were utilized to determine if there is a statistical difference between use or lack of use of ROM systems (Dependent Variable, DV) and supervisor characteristics (highest degree earned, theoretical orientation, model of supervision, courses in supervision, years since completing graduate school, years practicing psychotherapy, years practicing supervision) (Independent Variable; IV). Additional one-way ANOVAs and chi-square tests of association were conducted using the same

independent variable but using current environmental setting items as the dependent variables.

Hypothesis 2. The second hypothesis stated **"**On average, supervisors who are more inclined towards prevention focused on the 'Regulatory Focus Scale' will be more likely to use ROM within supervision." Means and Standard Deviations were calculated. A follow-up chi-square was utilized to determine if there is a statistical difference between the use or non-use of ROM systems (DV) and the score on the "Regulatory Focus Scale" (IV). An additional multiple linear regression was conducted in order to further examine the data, looking at the total scores of prevention and promotion and whether or not they reported using ROM within supervision. A detailed explanation of the regression analysis is explained within the following section.

Hypothesis 3. The third hypothesis stated **"**On average, supervisors who used ROM systems or received graduate/post graduate training in ROM systems will be more likely to use ROM within supervision." A series of chi-square tests of association were conducted to determine if there is a significant difference between the use of ROM within supervision (DV) and using or receiving graduate/post graduate training in ROM systems (IV).

Hypothesis 4. The fourth hypothesis stated "On average, supervisors who did not use or receive graduate/post-graduate training in ROM systems will be less likely to use ROM within supervision." A series of chi-square tests of association were conducted to determine if there is a significant difference between the lack of use of ROM within supervision (DV) and not using or receiving graduate/post-graduate training in ROM systems (IV).

Hypothesis 5. The fifth hypothesis stated "On average, of supervisors who do utilize ROM within supervision, the format of supervision (Audio/Video Recording, Case Review, Live Supervision) will not reveal any statistically significant differences." A series of chi-square tests of association were conducted in order to determine whether there is a significant difference between the use of ROM within supervision (DV) and the format of supervision (IV).

Hypothesis 6. The sixth hypothesis stated "On average, within the group of supervisors who do not utilize ROM within supervision, format of supervision (Audio/Video Recording, Case Review, Live Supervision) will not reveal any statistically significant differences." A series of chi-square tests of association were conducted in order to determine whether there is a significant difference between the lack of use of ROM within supervision (DV) and the format of supervision (IV).

Hypothesis 7. The seventh hypothesis stated "Other variables (age, gender, ethnicity, etc.) will have no statistically significant correlation with the use/lack of use or ROM systems in supervision." A series of chi-square tests of association and independent sample t-tests were conducted in order to determine if there was a statistical difference between these variables and use or lack of use of ROM systems within supervision.

Open-ended statement analysis. Phenomenological analysis was utilized in order to analyze the open-ended questions (Atwood & Stolorow, 1993). Analysis was conducted through the exploration of themes, as suggested by Bazeley (2013). The responses were coded and analyzed by two coders and consisted of five steps. The second coder, a student within the UAF-UAA Clinical-Community Psychology Ph.D. program, was chosen due to his knowledge of the literature regarding psychotherapy and

supervision practices as well as their familiarity with qualitative methodology. Throughout each of the following steps, detailed notes documenting how codes and themes were developed were taken and recorded. Once the data was collected, the first step consisted of the initial meaning making. The data was organized into general statements and the data was then examined for central themes. This step consisted of the coders discussing the initial themes that were observed within the data. The coders then reviewed the initial codes together in an effort to identify overarching themes or redundancy. The central themes were examined in regard to the study questions, and each theme was then clustered in an effort to further understand the data. The last step consisted of integrating the clusters to yield a description of the study topic. The results of the analysis was then recorded and reported. A detailed description of the analysis process can be found in the following section.

Chapter 5 Results

Quantitative Results

Preliminary analyses. The major goal of this investigation sought to explore how supervisors identify and address non-responsive and deteriorating patients within the context of supervision. Furthermore, it aimed to explore whether regulatory focus correlated with the use or non-use of outcome measures within supervision. Various tests, including one-way ANOVAs, independent t-tests, and chi-square tests of association were performed in order to examine what methods supervisors are currently using. Two-hundred and one participants responded to the survey sent out via e-mail and list-serv postings. Of the 201 responses, 181 participants met inclusion criteria to participate within the study; namely, these individuals were currently providing supervision to supervisees in clinical practice. The analyses were completed using the results from these 181 participants.

Missing values and imputation of data. The data was screened for missing values within the data set. Survey items regarding, "age," "ethnicity," "degree type," "number of courses in supervision," "years since completing graduate school," "years practicing psychotherapy," and "years practicing supervision" were the only items which contained non-responses. Less than 6 participants failed to provide complete entries. However, failure to answer these demographic items did not result in exclusion from the study. It was determined by researchers that these participants completed the majority of the survey items and the overall amount of missing values did not have a significant impact on the planned analyses. All 181 participants completed each of the items pertaining to

identifying treatment non-responders within supervision, working with treatment non-responders within supervision and the Regulatory Focus Scale.

Demographic information. Table 1 consists of the descriptive statistics, which includes demographic information and supervisor characteristics of the sample.

Table 1
Descriptive Analysis

Characteristic	Total Participants (*n* = 181)			
	n	%	*M*	*SD*
Age	179		41.48	12.10
Gender	181			
Male	56	30.93		
Female	117	64.64		
Prefer Not to Answer	1	0.55		
Other	7	3.86		
Ethnicity	180			
White	155	86.11		
Latino/Hispanic	10	5.56		
Black/African American	6	3.33		
Asian	5	2.78		
Native American/Alaskan Native	2	1.11		
Other	2	1.11		
Primary Placement	181			
University Counseling Center	50	27.62		
Hospital	40	22.09		
Private Practice	31	17.12		
Community Health Center	25	13.81		
Other	17	9.39		
Inpatient Care Facility	6	3.31		
Correctional Facility/Prison	5	2.76		
Primary Care Facility	4	2.21		
Residential Care Facility	2	1.10		
Training Background	180			
Ph.D./Psy.D	129	71.66		
M.S.W	32	17.78		
M.A./M.S.	17	9.44		
M.D./D.O.	2	1.11		

Table 1 cont.

Supervisor Characteristic	Total Participants (n = 181)			
	n	%	*M*	*SD*
Use of ROM in Graduate Training	181			
Yes	146	80.66		
No	34	18.78		
Not Applicable	1	0.55		
Importance of ROM in Clinical Training	181			
Yes	99	54.70		
No	68	37.56		
Unsure	14	7.73		
Received Training in ROM Use	181			
Yes	149	82.32		
No	31	17.12		
Not Applicable	1	0.55		
Use ROM in Current Placement	181			
Yes	109	60.22		
No	72	39.78		
Courses in Supervision	179		1.64	2.25
Years Since Completing Graduate School	180		10.81	9.11
Years Practicing Psychotherapy	180		13.41	9.30
Years Practicing Supervision	180		8.69	8.45
Theoretical Orientation	181			
Integrative/Eclectic	67	37.01		
Behavioral (Cognitive-Behavioral)	55	30.38		
Humanistic (Client Centered/Process/Existential)	20	11.05		
Psychoanalytic/Psychodynamic	23	12.71		
Other	16	8.84		
Supervisory Style Matches Theoretical Orientation	181			
Yes	173	95.58		
No	6	3.31		
Not Applicable	2	1.10		
Number of Hours of Supervision	175		1.71	1.01
Number of Supervisees	181		4.24	11.67

Supervisors were asked to respond to 29 questions regarding how they identify and address non-responsive and deteriorating patients within the context of supervision.

These questions were answered on a 4-point Likert Scale with 1 = Never, 2 = Sometimes, 3 = Frequently, and 4 = Always. The descriptive results can be seen in Table 2.

Table 2
Descriptive Analysis: Identifying and Addressing Treatment Non-responders

Identifying treatment non-responders	***n***	***M***	***SD***
1.Supervisee Judgment	181	2.82	.598
2.Supervisee to identify high symptom distress	181	2.93	.638
3.Supervisee conceptualizations	181	2.80	.664
4. Unsolicited feedback from supervisee patient	181	2.08	.924
5. Supervisee to facilitate feedback in session	181	2.88	.786
6. Supervisor clinical judgment	181	3.39	.601
7. Video/audio/live supervision	181	2.34	.967
8. Outcome measures	181	2.24	.927
Addressing treatment non-responders:			
9. Encourage to discuss	181	3.61	.554
10. Facilitate discussion with supervisee	181	3.53	.553
11. Encourage manualized treatment	181	2.18	.851
12. Attend to therapeutic relationship	181	3.41	.657
13. Reevaluate treatment goals/tasks	181	3.16	.693
14. Encourage to give/receive feedback about therapeutic relationship	181	2.94	.701
15. Engage in process conversation	181	2.76	.704
16. Supervisee clinical judgment	181	3.12	.652
17. Direct instructions	181	2.56	.678
18. Focus on readiness of change	181	2.71	.689
19. Discuss social support	181	2.83	.674
20. Enact support interventions	181	2.40	.705
21. Explore patient experience	181	2.80	.741
22. Support and positive feedback to patient	181	2.59	.649
23. Refer to psychiatric/medical provided	181	2.25	.595

Table 2 cont.

24. Refer to alternate treatment modality	181	2.13	.531
25. Encourage to re-conceptualize	181	2.51	.620
26. Encourage to re-consider diagnosis	181	2.13	.452
27. Encourage to alter treatment plan	181	2.32	.545
28. Refer to another clinician	181	1.81	.406
29. Seek consultation with another supervisor	181	2.14	.673

Supervisors were then asked to respond to 10 questions regarding regulatory focus. The questions were answered on a 7-point Likert Scale with 1 = Definitely Untrue, 2 = Not True, 3 = Probably Not True, 4 = Neither True Nor Untrue, 5 = Probably True, 6 = True, and 7 = Definitely True. The descriptive results can be found in Table 3.

Table 3
Descriptive Analysis: Regulatory Focus Scale

Regulatory Focus Scale	***n***	***M***	***SD***
1) I prefer to work without instruction from others	181	3.89	1.57
2) Rules and regulations are helpful and necessary to me**	181	2.70	1.09
3) For me, it is very important to carry out the obligations placed on me	181	6.28	0.73
4) I generally solve problems creatively	181	5.31	1.01
5) I'm not bothered about reviewing or checking things very closely**	181	4.41	1.81
6) I like to do things in a new way	181	4.46	1.13
7) I always try to make my work as accurate and error-free as possible	181	5.90	0.93

Table 3 cont.

8) I like trying out lots of different things, and am often successful at doing so	181	5.06	0.97
9) It is important to me that my achievements are recognized and valued by other people	181	4.94	1.29
10) I often think about what other people expect of me	181	5.15	1.22

** indicates the item is reverse coded

Sample representativeness. In an effort to better understand the representativeness of the current sample, results of this study were compared to published studies that also examined supervisor demographic variables. The first sample comparison came from a study conducted by Rousmaniere and colleagues (2014). Their study collected archival data from a community-based, non-profit counseling center in Western Canada (Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2014). While this study did not explore all of the same demographic characteristics as the current sample, the variables that did overlap included gender and degree type. Their sample consisted primarily of females, with nearly half of participants holding M.S. Psych degrees (Rousmaniere et al., 2014). Their sample appears to be similar to the current sample in regard to gender, where the predominant gender identity was reported as female. Additionally, the current sample has the majority of participants holding a Ph.D. The difference in comparisons of this demographic characteristic is likely due to pointed nature of the survey, which was primarily sent to internship training directors and university program directors, where individuals in these positions often hold Ph.Ds.

A second sample comparison examined a study conducted by Cheon, Blumer, Shih, Murphy and Sato (2009). Their study looked at supervisors and supervisees who were involved in academic programs across the United States, exploring the influence of supervisor-supervisee matching, role conflict and the supervisory relationship on supervisee satisfaction. As with the last comparison sample, this study did not cover the same demographic characteristics, however age, gender, degree, and race were examined in both studies. Their sample was primarily comprised of participants who identified as White, female, doctoral level providers with an average age of 45-49 years (Cheon et al., 2009). The samples appear to be similar to the current sample in ethnicity and degree level, where the predominant ethnicity was identified as "White" and degree level "Ph.D./Psy.D". Additionally, the samples are similar in age of participants. Furthermore, the current sample comprised of 64% of participants identifying as female, significantly higher than the comparison's sample of 51%.

In another study exploring conflict within supervision, Nelson and colleagues (2008) examined 12 participants and explored how they handled conflict and processing within supervision. Researchers reported that most participants identified as female and all participants identified as White. Furthermore, seven participants indicated they were licensed psychologists, 4 were counselors and 1 indicated they were a clinical social worker (Nelson, Barnes, Evans, & Triggiano, 2008). A quarter of the participants indicated that they took an "eclectic" approach in their theoretical orientation, and on average, supervisors had 20.2 years of supervisory experience. The samples appear to be similar in most regard; however, it should be noted that this comparative sample was

extremely limited in cultural diversity (all participants identified as White) and therefore is cautiously used as a comparative sample with the current study.

A study conducted by Reese et al. (2017) was used as another comparison sample for the current sample. Reese and colleagues sent out an online survey to participants who were psychotherapy researchers and clinical supervisors. It should be noted that clinical supervisors made up 82% of the sample, and was therefore deemed an appropriate comparison sample. As with previous comparisons, this study did not cover the same demographics as the current sample, however overarching characteristics included: ethnicity, gender, age, and theoretical orientation.

It should be noted that each of the above comparison samples were limited in the reported demographics. In a systematic review looking at clinical supervisors conducted by Milne, Sheikh, Pattison, and Wilkinson (2011), researchers discerned that studies regarding supervisors contained a limited account of demographic characteristics, resulting in these studies being deemed an unrepresentative sample. Researchers went on to indicate that future work within the field should work towards reporting more detailed demographic characteristics (Milne et al., 2011). These results indicate that there are limited reported demographics in existing literature surrounding clinical supervision, which likely explains the limited shared demographic characteristics found between the comparison samples and the current sample. In summary, despite a limited overlap in demographic characteristics, when comparing doctoral level supervisors of the comparison samples to the current sample, overall similarities can be found in regard to ethnicity (White), gender (Female), and theoretical orientation (Integrative). A detailed comparison can be found in Table 4.

Table 4
Descriptive Analysis: Sample Comparisons

Sample	Characteristic						
				Credential			
	Gender	Ethnicity	Avg. Age	Doctorate	Master's	Theoretical Orientation	Avg. Years Supervising
Rousmaniere, et al., 2014	Female (69.57%)	--	--	21.74%	77.91%	--	--
Cheon et al., 2009	Female (51.5%)	White (88.6%)	45-49	70.5%	--	--	--
Nelson et al., 2008	Female (66.7%)	White/Caucasian (100%)	--	83.3%	16.7%	Eclectic (25%)	20.2
Reese et al., 2017	Female (46.51%)	White (90.48%)	51.02	--	--	Integrative (38%)	--
Current Sample, 2018	Female (64.3%)	White (85.2%)	52.4	70.9%	26.9%	Integrative/ Holistic/Eclectic (37.74%)	8.69 (SD = 8.45)

Statistical analyses. Due to the exploratory nature of this design, various hypotheses were proposed within the current data set. As such, multiple statistical tests were conducted in an effort to discern significant findings. However, the application of multiple analyses increased the likelihood of Type I error. To address this, family-wise error rate was calculated due to the large number of analyses conducted for each hypothesis, in order to protect against the likelihood of a false positive. Given that this calculation is based on the principle that the hypotheses are content specific, it was determined that a family-wise error rate would be applied by hypotheses. The family-wise error rate was calculated by dividing the widely accepted alpha level of $p < .05$ by the number of tests being run within the hypotheses (Benjamin & Hochberg, 1995). Another important point that should be discussed centers around the cell frequencies within the analyses. The nature of this study and its research questions called for the use of multiple chi-square tests of association. This statistical analysis generally presupposes an independence of observations and cell frequencies of at least five. (Yates, Moore, & McCabe, 1999). It should be noted that some variables within these analyses violated these assumptions. However, according to Yates and colleagues (1999), results are still interpretable if 1) "Each observation is independent of all others; and 2) No more than 20% of the expected counts are less than 5 and all individual expected counts are 1 or greater" (p.734). Grounded with these guidelines, the majority of the chi-square analyses were interpretable. Though the majority of the analyses followed these assumptions and were, thus, able to be interpreted, certain variables were unable to be combined into categories that would provide a high enough cell count. For example, participants did not endorse specific items with a high enough frequency regarding theoretical orientation and

primary placement, technically violating the assumptions of the statistical analysis. To state plainly, there are some analyses in the following sections that have been interpreted and reported that violate the assumptions of the conducted test. These results have been interpreted with caution, and in addition to the adjusted alpha level, may still provide meaningful information pertaining to the research questions.

Hypothesis 1. "On average, clinical supervisors are not utilizing ROM systems as part of clinical supervision practices to identify non-responders."

Degree type and ROM. A chi-square test of association was performed to examine the relationship between degree type and use of routine outcome measures within the context of supervision. Cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (0.0%) cells have expected count less than 5. The minimum expected count is 12.25. Responses that consisted of a doctoral level degree (Ph.D./Psy.D, M.D./D.O) were combined into one category and responses that consisted of a master's level degree (M.A./M.S.,M.S.W) were combined into one category. This was done as this study aims to explore level of degree and ROM use/lack of use within supervision rather than individual degree types and ROM use/lack of use within supervision. Of the 131 participants who held a doctoral degree, 101 reported that they use ROM within the context of supervision and 30 did not. Of the 49 who reported holding a master's level degree, 34 participants indicated that they use ROM within the context of supervision and 15 do not. A phi coefficient was calculated to assess the strength of this relationship, Φ =.08 [.0062, .23]. This corresponds to a small effect size. Fisher's Exact Test = .33, indicating no significance. Family-wise error was calculated using the aforementioned process, which was calculated to be .003. Based on the adjusted

alpha level, this was not a statistically significant association, χ^2 (1) = 1.13, p = .288. The nature of the relationship indicates that the level of degree did not result in a statistically significant higher proportion of ROM users versus non-users. Results for the chi-square test can be found in Table 5.

Table 5

Results of Chi-square Test and Degree Type for ROM Users vs. Non-Users

Indicated ROM Use	Degree Type	
	Ph.D./Psy.D/M.D./D.O	M.A/M.S./M.S.W
Yes	101 (56.11)	34 (18.88)
No	30 (16.66)	15 (8.33)

Note. χ^2 =1.13*, *df*=1, Numbers in parentheses indicate column percentages.
*p>.003

Theoretical orientation and ROM. A chi-square test of association was performed to examine the relationship between theoretical orientation and use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (0.0%) cells have expected count less than 5. The minimum expected count is 3.98. Responses that consisted behavioral approaches (Behavioral, CBT) were combined into one category, combination responses (Eclectic, Integrationist) were combined into one category, and humanistic approaches (Existential, Humanistic, and Process) were combined into one category. This was done as this study aims to general arching theoretical orientation and ROM use/lack of use within supervision rather than specific orientations and ROM use/lack of use within supervision. Of the 55 participants who identified practicing behavioral theoretical orientations, 44 participants reported that they use ROM within the context of supervision and 11 did not. Of the 67 participants who identified combination

responses, 59 participants reported that they use ROM within the context of supervision and 8 did not. Of the 20 participants who identified a humanistic orientation, 12 participants reported that they use ROM within the context of supervision and 8 did not. Of the 23 participants who identified a psychodynamic approach, 12 reported that they use ROM within the context of supervision and 11 did not. Of the 16 participants who identified an "other" approach, 9 indicated that they use ROM within the context of supervision and 7 did not. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .32$ [.18, .48]. This corresponds to a medium effect size. Based on the adjusted alpha level, this was a statistically significant association, $\chi^2 (4) = 18.69$, $p = .001$. The nature of the relationship indicates that theoretical orientation preference results in a statistically significant difference in supervisory ROM use versus non-use. Based on visual inspection of the data, the results indicate that participants who reported their theoretical orientation as "Behavioral/CBT" and "Eclectic/Integrationist" were more likely to use ROM within supervision than those who indicated other theoretical orientations. Results for the chi-square test can be found in Table 6.

Table 6

Results of Chi-square Test for Theoretical Orientation and Supervisory ROM Use vs. Non-Use

Indicated ROM Use	Theoretical Orientation				
	Behavioral/ CBT	Eclectic/ Integrationist	Existential/ Humanistic/ Process	Psychodynamic	Other
Yes	44 (24.31)	59 (32.59)	12 (6.63)	12 (6.63)	9 (4.97)
No	11 (6.08)	8 (4.42)	8 (4.42)	11 (6.08)	7 (3.87)

Note. $\chi^2 = 18.69$*, *df*=4, Numbers in parentheses indicate column percentages.
*$p < .003$

Supervision style and ROM. A chi-square test of association was performed to examine the relationship between supervision style and use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 1 cell (25.0%) has an expected count less than 5. The minimum expected count is 1.99. Of the 173 participants who indicated that their supervisory style matches their theoretical orientation, 130 reported that they use ROM within the context of supervision and 43 did not. Of the eight participants who reported that their supervisory style did not match their theoretical orientation, six participants reported that they use ROM within the context of supervision and two did not. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .00$ [-.15, .15]. This corresponds to a small effect size. Based upon the adjusted alpha level, this was not a statistically significant association, $\chi^2(1) = .00$, $p = .993$. The nature of the relationship indicates that supervisory style does not result in a statistically significant higher proportion of supervisory ROM use versus non-use. Results for the chi-square test can be found in Table 7.

Table 7

Results of Chi-square Test for Supervisory Style and ROM Users vs. Non-Users

Indicated ROM Use	Supervisory Style Matches	
	Yes	No
Yes	130 (71.82)	43 (23.76)
No	6 (3.31)	2 (1.11)

Note. $\chi^2 = .00$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p > .003$

Number of Supervision Courses and ROM. An independent samples t-test was conducted to compare the number of supervision courses completed for those who

indicated "Yes" to the use of ROM within supervision, $M = 1.68$, $SD = 2.49$, and the number of supervision courses completed for those who indicated "No" to the use of ROM within supervision, $M = 1.50$, $SD = 1.28$, 95% CI [-.75, .39]. A non-significant difference was found, t (143.66) = -.63, $p = .53$. The difference represents a small effect size ($d = .01$) indicating that on average, there was no statistical difference in number of supervision courses and participants who choose to utilize ROM within supervision and those who do not.

Number of years since graduate school and ROM. An independent samples t-test was conducted to compare the number of years since graduate school and those who indicated "Yes" to the use of ROM within supervision, $M = 10.46$, $SD = 9.21$, and the number of years since graduate school for those who indicated "No" to the use of ROM within supervision, $M = 11.89$, $SD = 18.82$, 95% CI [-.75, .39]. A non-significant difference was found, t (75.69) = -.92, $p = .36$. The difference represents a small effect size ($d = .2$) indicating that on average, there was no statistical difference in number of supervision courses and participants who choose to utilize ROM within supervision and those who do not.

Years practicing psychotherapy and ROM An independent samples t-test was conducted to compare the number of years practicing psychotherapy and those who indicated "Yes" to the use of ROM within supervision, $M = 13.15$, $SD = 9.12$, and the number of years practicing psychotherapy for those who indicated "No" to the use of ROM within supervision, $M = 14.20$, $SD = 9.88$, 95% CI [-2.28,4.37]. A non-significant difference was found, t (70.47) = -.63, $p = .53$. The difference represents a small effect size ($d = .1$) indicating that on average, there was no statistical difference in years

practicing psychotherapy and participants who choose to utilize ROM within supervision and those who do not.

Years practicing supervision and ROM An independent samples t-test was conducted to compare the number of years practicing supervision and those who indicated "Yes" to the use of ROM within supervision, $M = 8.46$, $SD = 8.41$, and the number of years practicing supervision for those who indicated "No" to the use of ROM within supervision, $M = 9.41$, $SD = 8.64$, 95% CI [-2.02, 3.91]. A non-significant difference was found, $t\ (71.25) = -.63$, $p = .53$. The difference represents a small effect size ($d = .1$) indicating that on average, there was no statistical difference in number of years practicing supervision and participants who choose to utilize ROM within supervision and those who do not.

Degree type and primary placement. A chi-square test of association was performed to examine the relationship between degree type and primary placement. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 2 cells (20.0%) cells have expected count less than 5. The minimum expected count is 5.99. Responses that consisted of a doctoral level degree (Ph.D./Psy.D, M.D./D.O) were combined into one category and responses that consisted of a master's level degree (M.A./M.S.,M.S.W) were combined into one category. Correctional facility/prison and other were combined into one category, primary care setting, hospital, inpatient care facility, and residential care facility were combined into one category, and educational system and university counseling center was combined into one category. This was done as this study aims to explore level of degree and general primary placement rather than individual degree types and primary placement.

Furthermore, the exploration of degree type and primary placement was not the main focus of this study.

Of the 131 participants who held a doctoral degree, 19 reported that they work in a community mental health setting, 20 indicated that they work in a correctional facility/prison or other, 49 indicated that they work in in a primary care setting, hospital, inpatient care facility, or residential care facility, 15 reported that they work in private practice and 28 reported that they work in a educational system or university counseling center. Of the 49 who reported holding a master's level degree, 6 reported that they work in a community mental health setting, two indicated that they work in a correctional facility/prison or other, two indicated that they work in in a primary care setting, hospital, inpatient care facility, or residential care facility, 16 reported that they work in private practice and 23 reported that they work in a educational system or university counseling center. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .44$ [.32, .77]. This corresponds to a medium effect size. Based on the adjusted alpha level, this was a statistically significant association, $\chi^2 (4) = 35.29, p = .00$). The nature of the relationship indicates that primary placement is statistically correlated with level of degree. Based on visual inspection of the data, results indicated that participants who reported working in a "Primary Care/Hospital/Inpatient/Residential" were more likely to hold doctoral level degrees than those who indicated other primary placements. Results for the chi-square test can be found in Table 8.

Table 8

Results of Chi-square Test for Primary Placement and Level of Degree

Primary Placement	Degree Type	
	Ph.D./Psy.D/M.D./D.O	M.A/M.S./M.S.W
Community Mental Health	19 (10.55)	6 (3.33)
Correctional Facility/ Prison/Other	20 (11.11)	2 (1.11)
Primary Care/Hospital/Inpatient/ Residential	49 (27.22)	2 (1.11)
Private Practice	15 (8.33)	16 (8.89)
Educational System/ University Counseling Center	28 (15.55)	23 (12.78)

Note. χ^2 =35.29*, *df*=4, Numbers in parentheses indicate column percentages.
*p<.003

Theoretical orientation and primary placement. A chi-square test of association was performed to examine the relationship between theoretical orientation and primary placement. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 11 cells (44.0%) cells have expected count less than 5. The minimum expected count is 1.94. Responses that consisted of a doctoral level degree (Ph.D./Psy.D, M.D./D.O) were combined into one category and responses that consisted of a master's level degree (M.A./M.S.,M.S.W) were combined into one category. Responses that consisted behavioral approaches (Behavioral, CBT) were combined into one category, combination responses (Eclectic, Integrationist) were combined into one category, humanistic approaches (Existential, Humanistic, and Process) were combined into one category. This was done as this study aims to explore general theoretical orientation and general primary placement rather than individual degree types and

primary placement. Furthermore, the exploration of theoretical orientation and primary placement was not the main focus of this study.

Of the 55 participants who identified practicing behavioral theoretical orientations nine reported working in a community mental health setting, 11 reported working in a correctional facility/prison or "other" setting, 20 reported working in a primary care setting, hospital, inpatient or residential care facility, 15 reported working in private practice, and 28 reported working in an educational system or university counseling center. Of the 67 participants who identified combination responses, 10 reported working in a community mental health setting, four reported working in a correctional facility/prison or "other" setting, 19 reported working in a primary care setting, hospital, inpatient or residential care facility, eight reported working in private practice, and 26 reported working in an educational system or university counseling center. Of the 20 participants who identified a humanistic orientation, one reported working in a community mental health setting, two reported working in a correctional facility/prison or "other" setting, three reported working in a primary care setting, hospital, inpatient or residential care facility, four reported working in private practice, and 10 reported working in an educational system or university counseling center. Of the 23 participants who identified a psychodynamic approach, four reported working in a community mental health setting, 5 reported working in a correctional facility/prison or "other" setting, six reported working in a primary care setting, hospital, inpatient or residential care facility, four reported working in private practice, and four reported working in an educational system or university counseling center. Of the 16 participants who identified an "other" approach, one reported working in a community mental health setting, four reported

working in a primary care setting, hospital, inpatient or residential care facility, six reported working in private practice, and five reported working in an educational system or university counseling center. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .42$ [.29, .60]. This corresponds to a medium effect size. Based upon the adjusted alpha level, this was not a statistically significant association, $\chi^2(4) = 31.47$, $p = .012$. The nature of the relationship indicates that theoretical orientation preference does not result in a statistically significant correlation in primary placement. It should be noted that having 11 cells (44.0%) with an expected count of less than 5, technically violates the assumptions of the chi-square test, but it was determined to be unavoidable by the researchers. It was determined, that attempting to further combine theoretical orientation or primary placement would not accurately represent the characteristics of the data set. Results for the chi-square test can be found in Table 9.

Table 9

Results of Chi-square Test for Primary Placement and Theoretical Orientation

Primary Placement	Theoretical Orientation				
	Behavioral/ CBT	Eclectic/ Integrationist	Existential/ Humanistic/ Process	Psycho-dynamic	Other
Community Mental Health	9 (4.97)	10 (5.52)	1 (0.55)	4 (2.21)	1 (0.55)
Correctional Facility/Prison/ Other	11 (6.08)	4 (2.21)	2 (1.10)	5 (2.76)	0 (0.00)
Primary Care/ Hospital/ Inpatient/ Residential	20 (11.05)	19 (10.50)	3 (1.66)	6 (3.31)	4 (2.21)
Private Practice	9 (4.97)	8 (4.42)	4 (2.21)	4 (2.21)	6 (3.31)

Table 9 cont.

Educational System/ University Counseling Center	6 (3.31)	26 (14.36)	10 (5.52)	4 (2.21)	5 (2.76)

Note. χ^2 =31.47*, *df*=16, Numbers in parentheses indicate column percentages.
*p<.003

Supervisory style and primary placement. A chi-square test of association was performed to examine the relationship between supervisory style and primary placement. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 5 cells (50.0%) cells have expected count less than 5. The minimum expected count is .97. Responses that consisted behavioral approaches (Behavioral, CBT) were combined into one category, combination responses (Eclectic, Integrationist) were combined into one category, humanistic approaches (Existential, Humanistic, and Process) were combined into one category. This was done as this study aims to explore supervisory style and general primary placement rather than individual degree types and primary placement. Furthermore, supervisory style and primary placement was not the main focus of this study.

Of the 173 participants who reported that their supervisory style matched their theoretical orientation, 25 reported working in a community mental health setting, 22 reported working in a correctional facility/prison or "other" setting, 48 reported working in a primary care setting, hospital, inpatient or residential care facility, 29 reported working in private practice, and 49 reported working in an educational system or university counseling center. Of the eight participants who reported that their supervisory style did not match their theoretical orientation, four reported working in a primary care

setting, hospital, inpatient or residential care facility, two reported working in private practice, and two reported working in an educational system or university counseling center. A phi coefficient was calculated to assess the strength of this relationship, Φ =.14 [.26,.56]. This corresponds to a small effect size. Based upon the adjusted alpha level, this was not a statistically significant association, χ^2 (4) = 3.82, p = .430). The nature of the relationship indicates that supervisory style does not result in a statistically significant correlation in primary placement. It should be noted that having 5 cells (50.0%) with an expected count of less than 5, technically violates the assumptions of the chi-square test, but it was determined to be unavoidable by the researchers. Results for the chi-square test can be found in Table 10.

Table 10

Results of Chi-square Test for Supervisory Style and Primary Placement

Primary Placement	Supervisory Style	
	Yes	No
Community Mental Health	25 (13.81)	0 (0.00)
Correctional Facility/Prison/Other	22 (12.15)	0 (0.00)
Primary Care/ Hospital/Inpatient/ Residential	48 (26.52)	4 (2.21)
Private Practice	29 (16.02)	2 (1.10)
Educational System/University Counseling Center	49 (27.07)	2 (1.10)

Note. χ^2 =3.82*, df=4, Numbers in parentheses indicate column percentages.
*p>.003

Number of supervision courses and primary placement. A one-way ANOVA was conducted to compare the number of supervision courses on those who indicated

"Community Mental Health", $M = 1.68$, $SD = 1.49$, 95% CI [1.06, 2.30], those who indicated "Correctional Facility/Other", $M = 1.9$, $SD = 1.57$, 95% CI [.48, 1.90] those who indicated "Primary Care Facility/Hospital/Inpatient Care Facility/Residential Care Facility", $M = 1.76$, $SD = 2.04$, 95% CI [1.19, 2.34] those who indicated "Private Practice", $M = 2.68$, $SD = 3.79$, 95% CI [1.29, 4.07], and those who indicated "Educational System/University Counseling Center", $M = 1.04$, $SD = 1.45$ 95% CI [.63, 1.45]. The overall F for the one-way ANOVA was statistically non-significant F (9,179) = 2.92, $p = .02$. This corresponded to an eta squared = .063; that is, about 6.3% of the variance in primary placement was predicable from number of supervision courses completed. This corresponds to a small effect size. While number of supervision courses varied in primary placement, no significant differences were found.

Number of years since graduate school and primary placement. A one-way ANOVA was conducted to compare the number of years since graduate school and those who indicated "Community Mental Health", $M = 9.40$, $SD = 6.49$, 95% CI [6.75, 12.08] those who indicated "Correctional Facility/Other, $M = 13.68$, $SD = 12.26$, 95% CI [8.25, 19.12] those who indicated "Primary Care Facility/Hospital/Inpatient Care Facility/Residential Care Facility", $M = 10.02$, $SD = 7.31$, 95% CI [7.98, 12.06] those who indicated "Private Practice", $M = 14.94$, $SD = 9.40$, 95% CI [11.49, 18.38] and those who indicated "Educational System/University Counseling Center", $M = 8.52$, $SD = 9.32$ 95% CI [5.87, 11.17] The overall F for the one-way ANOVA was statistically non-significant F (4, 179) = 3.34, $p = .01$. This corresponded to an eta squared =.071; that is, about 7.1% of the variance in primary placement was predicable from number of years since completing graduate school. This corresponds to a small effect size. In other words,

while the number of years since completing graduate school varied in primary placement, no significant differences were found.

Years practicing therapy and primary placement. A one-way ANOVA was conducted to compare the number of years practicing therapy and those who indicated "Community Mental Health", $M = 12.32$, $SD = 7.09$, 95% CI [9.39, 15.25] those who indicated "Correctional Facility/Other, $M = 13.68$, $SD = 12.26$, 95% CI = [12.15, 22.57] those who indicated "Primary Care Facility/Hospital/Inpatient Care Facility/Residential Care Facility", $M = 10.02$, $SD = 7.31$, 95% CI [10.15, 14.50] those who indicated "Private Practice", $M = 14.94$, $SD = 9.40$, 95% CI [12.08, 19.08] and those who indicated "Educational System/University Counseling Center", $M = 8.52$, $SD = 9.32$, 95% CI [9.24, 14.83]. The overall F for the one-way ANOVA was statistically non-significant F (4, 180) = 2.00, $p = .10$. This corresponded to an eta squared = .043; that is, about 4.3% of the variance in primary placement was predicable from number of years practicing therapy. This corresponds to a small effect size. While the number of years practicing therapy varied in primary placement, no significant differences were found.

Years practicing supervision and primary placement. A one-way ANOVA was conducted to compare the number of years practicing supervision and those who indicated "Community Mental Health", $M = 7.29$, $SD = 6.20$, 95% CI [4.64, 9.76], those who indicated "Correctional Facility/Other, $M = 12.86$, $SD = 10.64$, 95% CI [8.14, 17.58] those who indicated "Primary Care Facility/Hospital/Inpatient Care Facility/Residential Care Facility", $M = 6.92$, $SD = 6.24$, 95% CI [5.17, 8.68] those who indicated "Private Practice", $M = 10.77$, $SD = 8.98$, 95% CI [7.48, 14.07] and those who indicated "Educational System/University Counseling Center", $M = 8.14$, $SD = 9.34$, 95% CI [5.51,

10.76]. The overall F for the one-way ANOVA was statistically non-significant F (9, 179) = 2.92, p = .02. This corresponded to an eta squared + .059; that is, about 5.9% of the variance in primary placement was predictable from the number of years practicing supervision. This corresponds to a small effect size. In other words, while the number of years practicing supervision varied in primary placement, no significant differences were found.

Hypothesis 2. "On average, supervisors who are more inclined towards prevention focused on the 'Regulatory Focus Scale' will be more likely to use ROM within supervision."

Regulatory Focus and ROM use within supervision. A chi-square test of association was performed to examine the relationship between regulatory focus and use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 2 cells (33.3%) cells have expected count less than 5. The minimum expected count is .75. Of the 47 participants who identified as being prevention focused, 15 reported that they used ROM within the context of supervision and 32 did not. Of the three participants who identified as promotion focused, two reported using ROM within supervision and 1 did not. Of the 131 participants who identified as indifferent, 28 participants reported using ROM within supervision and 103 did not. A phi coefficient was calculated to assess the strength of this relationship, Φ = .16 [.017, .311]. This corresponds to a small effect size. The generally used alpha level of $p < .05$ was used. This was a statistically significant association, χ^2 (2) = 4.91, p = .086). The nature of the relationship indicates that regulatory focus does not result in a statistically significant higher proportion of ROM

users within supervision versus non-users. Results for the chi-square test can be found in Table 11.

Table 11
Results of Chi-square Test for Regulatory Focus and ROM Use within Supervision

Indicated ROM Use	Regulatory Focus		
	Indifferent	Prevention	Promotion
Yes	28 (15.47)	15 (8.29)	2 (1.10)
No	103 (56.91)	32 (17.68)	1 (0.55)

Note. χ^2 =4.91*, *df* = 1, Numbers in parentheses indicate column percentages.
*p<.05

Though it was originally believed that the data could be examined using a chi-square test of association, the data showed an unusually high number of "indifferent" responses. Furthermore, the low number of "promotion" responses resulted 33.3% of cells having a cell count of less than 5, a violation of the statistical test. Additionally, it was determined by the researcher that if the results of the indifferent category were discarded, it would further violate the assumptions of the statistical test. Due to these reasons, it was decided by the researcher to conduct a multiple linear regression in order to further examine the data, looking at the total scores of prevention and promotion and whether or not they reported using ROM within supervision. A multiple linear regression was decided upon due to the fact that the data fit the assumptions of the linear model, namely that the modeled probabilities are moderate, between .20 and .80 (Von Hippel, 2015). Furthermore, because the data fits the assumptions of both the linear and logistical models, both would fit equally well, as well as yield nearly identical results. Therefore, the linear model was decided upon due to its ease of interpretation (Hellevik, 2009; Von Hippel, 2015).

A multiple linear regression was calculated to predict ROM use in supervision based on prevention and promotion scores. A significant regression equation was found ($F(2)178 = 4.51, p = .012$), with an r^2 of .048. Participant's predicted ROM use in supervision is equal to 1.530 -.01 (Prevention) - .03 (Promotion), where prevention is coded in total score and promotion is coded in total score. Total promotion scores were a significant predictor of ROM use within supervision. Holding prevention scores constant, a decrease of -.03 in participants' promotion score results in increased likelihood of using ROM within supervision. In other words, changes in the promotion score in relation to the prevention score significantly impacted ROM use within supervision. The results suggest that participants were more likely to use ROM as their total promotion scores decreased. The results of the multiple linear regression can be found in Table 12.

Table 12
Results of Multiple Linear Regression for Regulatory Focus and ROM Use within Supervision

Source	B	SE B	β	t	p
Promotion	-.03	.01	-.21	-2.86	.00
Prevention	-.01	.01	-.08	-1.08	.28

*$p < .05$

Hypothesis 3. "On average, supervisors who used ROM systems or received graduate/post graduate training in ROM systems will be more likely to use ROM within supervision."

Hypothesis 4. "On average, supervisors who did not use or receive graduate/post-graduate training in ROM systems will be less likely to use ROM within supervision." Family-wise error was computed for hypotheses three and four using the aforementioned process with an adjusted alpha level of $p < .01$.

Graduate clinical training and ROM use in supervision. A chi-square test of association was performed to examine the relationship between graduate clinical training in ROM use and use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (0.0%) cells have expected count less than 5. The minimum expected count is 8.31. Of the 146 participants who identified as having been trained in ROM during graduate clinical training, 122 reported that they utilize ROM within supervision and 24 did not. Of the 34 participants who identified as not receiving training in ROM systems during graduate clinical training, 14 reported using ROM within supervision and 20 did not. It should be noted that individuals who reported "not applicable" regarding graduate school training in ROM were not included in the analysis. This was done as this analysis aims to examine the relationship between graduate school training and no graduate school training and ROM use/lack of use within supervision. Results that indicated "not applicable" were deemed unnecessary by the researchers. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .39$ [.26, .56]. This corresponds to a medium effect size. Based on the adjusted alpha level, this was a statistically significant association, $\chi^2 (1) = 29.56$, $p = .00$. Analysis failed to reject the null hypothesis. The nature of the relationship indicates that receiving training in ROM during graduate clinical training results in a statistically significant higher proportion of ROM users within supervision versus non-users. Results for the chi-square test can be found in Table 13.

Table 13

Results of Chi-square Test for Graduate School Training and ROM Use within Supervision

Indicated ROM Use	Graduate School Training	
	Yes	No
Yes	122 (67.78)	14 (7.78)
No	24 (13.33)	20 (11.11)

Note. $\chi^2 = 4.36$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p < .01$

Importance of ROM use in clinical training and ROM use in supervision. A chi-square test of association was performed to examine the relationship between the importance of ROM use in clinical training and the use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (0.0%) cells have expected count less than 5. The minimum expected count is 16.69. Of the 99 participants who reported that ROM use was an important part of their clinical training, 87 reported that they utilize ROM within supervision and 12 did not. Of the 68 participants who reported that ROM use was not an important part of their clinical training, 39 reported using ROM within supervision and 29 did not. It should be noted that individuals who reported "unsure" regarding the importance of ROM within their clinical training were not included in the analysis. This was done as this analysis aims to examine the relationship between importance and non-importance of ROM within clinical training and ROM use/lack of use within supervision. Results that indicated "unsure" were deemed unnecessary by the researchers. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .35$ [.21, .51]. This corresponds to a medium effect size. Based upon the adjusted alpha level, this was a statistically significant association, $\chi^2 (1,) = 20.28$ $p = .00$). Analysis failed to reject the null hypothesis. The nature of the relationship indicates

the importance placed on ROM during clinical training results in a statistically significant higher proportion of ROM users within supervision versus non-users. Results for the chi-square test can be found in Table 14.

Table 14
Results of Chi-square Test for Importance of ROM and ROM Use within Supervision

Indicated ROM Use	Importance of ROM Use In Clinical Training	
	Yes	No
Yes	87 (52.09)	39 (23.35)
No	12 (7.18)	29 (17.36)

Note. $\chi^2 = 20.28$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p<.01$

Training and ROM use within supervision. A chi-square test of association was performed to examine the relationship between receiving any training in ROM and the use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (0.0%) cells have expected count less than 5. The minimum expected count is 7.58. Of the 149 participants who reported that receiving training in ROM, 122 reported that they utilize ROM within supervision and 27 did not. Of the 31 participants who reported that they did not receive training in ROM, 14 reported using ROM within supervision and 17 did not. It should be noted that individuals who reported "not applicable" regarding the importance of ROM within their clinical training were not included in the analysis. This was done as this analysis aims to examine the relationship between receiving/not receiving training in ROM and ROM use/lack of use within supervision. Results that indicated "not applicable" were deemed unnecessary by the researchers. A phi coefficient was calculated to assess the strength of this relationship, Φ

= .32[.18, .48]. This corresponds to a medium effect size. Based upon the adjusted alpha level, this was a statistically significant association, χ^2 (1) = .18.73, p = .00). Analysis failed to reject the null hypothesis. The nature of the relationship indicates receiving training in ROM results in a statistically significant higher proportion of ROM users within supervision versus non-users. Results for the chi-square test can be found in Table 15.

Table 15
Results of Chi-square Test for Received Training and ROM Use within Supervision

Indicated ROM Use	Received Training in ROM	
	Yes	No
Yes	122 (67.78)	14 (7.78)
No	27 (15.00)	17 (9.44)

Note. χ^2 =18.72*, *df* = 1, Numbers in parentheses indicate column percentages.
*p<.01

Required at primary placement and ROM. A chi-square test of association was performed to examine the relationship between the requirement of ROM at current primary placement and the use of routine outcome measures within the context of supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (0.0%) cells have expected count less than 5. The minimum expected count is 17.90. Of the 109 participants who reported that the use of ROM was required at their primary placement, 101 reported that they utilize ROM within supervision and eight did not. Of the 72 participants who reported that the use ROM was not required at their primary placement, 35 reported using ROM within supervision and 37 did not. It should be noted that individuals who reported "not applicable" regarding the requirement of ROM at their primary placement were not

included in the analysis. This was done as this analysis aims to examine the requirement of ROM at their primary placement and ROM use/lack of use within supervision. Results that indicated "not applicable" were deemed unnecessary by the researchers. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .50$ [.39, .69]. This corresponds to a large effect size. Based upon the adjusted alpha level, this was a statistically significant association, $\chi^2(1) = 45.04$, $p = .00$. Analysis failed to reject the null hypothesis. The nature of the relationship indicates that the requirement of ROM at primary placement results in a statistically significant higher proportion of ROM users within supervision versus non-users. Results for the chi-square test can be found in Table 16.

Table 16
Results of Chi-square Test for Requirement of ROM at Primary Placement and ROM Use within Supervision

Indicated ROM Use	Requirement at Primary Placement	
	Yes	No
Yes	101 (55.80)	35 (19.34)
No	8 (4.42)	37 (20.44)

Note. $\chi^2 = 45.04$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p < .01$

Hypothesis 5. "On average, of supervisors who do utilize ROM within supervision, the format of supervision (audio/video recording, case review/other, live supervision) will not reveal any statistically significant differences."

Hypothesis 6. "On average, within the group of supervisors who do not utilize ROM within supervision, format of supervision (audio/video recording, case review/other, live supervision) will not reveal any statistically significant differences."

Family-wise error rate was computed for hypotheses five and six using the previously mentioned process with an adjusted alpha level of $p < .02$ for the following analyses.

Audio/video recording and ROM use within supervision. A chi-square test of association was performed to examine the relationship between audio/video recording and ROM use within supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 1 cell (25.0%) cells have expected count less than 5. The minimum expected count is 8.20. Responses that consisted of audio and video recording were combined into one category. This was done as this study aims to explore overarching supervision format and ROM use within supervision. Furthermore, it was determined by researchers that audio and video recordings captured similar properties of supervision and could therefore be combined into one category.

Of the 33 participants who reported that they utilized audio/video recording within supervision, 29 reported using ROM within supervision and four did not. Of the 148 participants who reported that they did not utilize audio/video recording, 107 reported using ROM within supervision and 41 did not. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .14$ [-.00, .29]. This corresponds to a small effect size. Based upon the adjusted alpha level, this was not a statistically significant association, $\chi^2 (1,) = 3.51, p = .061$). Analysis failed to reject the null hypothesis. The nature of the relationship indicates that the use of audio and video recording did not result in a statistically significant higher proportion of ROM user within supervision. Results for the chi-square test can be found in Table 17.

Table 17

Results of Chi-square Test for Audio/Video Recording and ROM Use

Indicated ROM Use	Use of Audio/Video Recording	
	Yes	No
Yes	29 (16.02)	107 (59.12)
No	4 (2.21)	41 (22.65)

Note. $\chi^2 = 45.04$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p > .02$

Case review/other and ROM use within supervision. A chi-square test of association was performed to examine the relationship between case review/other and ROM use within supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (00.0%) cells have expected count less than 5. The minimum expected count is 15.66. Responses that consisted of case review and "other" were combined into one category. This was done as this study aims to explore overarching supervision format and ROM use within supervision. Furthermore, it was determined that the "other" category consisted primarily of case review examples and could therefore be combined into one category with case review. Of the 118 participants who reported that they utilized case review/other within supervision, 85 reported using ROM within supervision and 33 did not. Of the 63 participants who reported that they did not utilize case review/other, 51 reported using ROM within supervision and 12 did not. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .10$ [-.05, .25]. This corresponds to a small effect size. Based upon the adjusted alpha level, this was not a statistically significant association, $\chi^2 (1) = 1.75$, $p = .186$). Analysis failed to reject the null hypothesis. The nature of the relationship indicates that the use of case review/other did not result in a statistically significant

higher proportion of ROM user within supervision. Results for the chi-square test can be found in Table 18.

Table 18

Results of Chi-square Test for Case Review/Other and ROM Use

Indicated ROM Use	Use of Case Review/Other	
	Yes	No
Yes	85 (46.96)	51 (28.18)
No	33 (18.23)	12 (6.63)

Note. $\chi^2 = 1.75$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p > .02$

Live supervision and ROM use within supervision. A chi-square test of association was performed to examine the relationship between live supervision and ROM use within supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (00.0%) cells have expected count less than 5. The minimum expected count is 7.46. Of the 30 participants who reported that they utilized live supervision, 22 reported using ROM within supervision and eight did not. Of the 151 participants who reported that they did not utilize live supervision, 114 reported using ROM within supervision and 37 did not. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .02$ [-.13, .17]. This corresponds to a small effect size. Based upon the adjusted alpha level, this was not a statistically significant association, $\chi^2 (1) = .063$, $p = .80$). Analysis failed to reject the null hypothesis. The nature of the relationship indicates that the use of live supervision did not result in a statistically significant higher proportion of ROM user within supervision. Results for the chi-square test can be found in Table 19.

Table 19

Results of Chi-square Test for Live Supervision and ROM Use

Indicated ROM Use	Use of Live Supervision	
	Yes	No
Yes	22 (12.15)	114 (62.98)
No	8 (4.42)	37 (20.44)

Note. $\chi^2 = .06$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p>.02$

Hypothesis 7. "Other variables (age, gender, ethnicity, etc.) will have no statistically significant correlation with the use/lack of use or ROM systems in supervision."

Age and ROM use. An independent samples t-test was conducted to compare age of those who indicated "Yes" to the use of ROM within supervision, $M = 41.10$, $SD = 11.83$, and the age for those who indicated "No" to the use of ROM within supervision, $M = 43.00$, $SD = 12.90$, 95% CI [-2.45, 6.24]. A non-significant difference was found, $t(70.50) = .87$, $p = .39$. The difference represents a small effect size ($d = .16$) indicating that on average, there was no statistical difference in number of supervision courses and participants who choose to utilize ROM within supervision and those who do not.

Gender and ROM use. A one-way ANOVA was conducted to compare the number of years practicing supervision and those who indicated "female", $M = .76$, $SD = .43$, 95% CI [.68,.84], those who indicated "Male", $M = .75$, $SD = .44$, 95% CI [.63, .87] and those who indicated "Other/Prefer Not to Answer", $M = .63$, $SD = .52$, 95% CI [.19, 1.06] . The overall F for the one-way ANOVA was statistically non-significant $F(2,181) = .36$, $p = .69$. This corresponded to an eta squared = .004; that is, about .4% of the variance in ROM use within supervision was predicable from gender. This is extremely

small effect size. In other words, while there is some variation between ROM use within supervision and gender, no significant differences were found.

Ethnicity and ROM use. A chi-square test of association was performed to examine the relationship between ethnicity and ROM use within supervision. Expected cell frequencies were examined to see whether there were any expected frequencies less than 5; 0 cells (00.0%) cells have expected count less than 5. The minimum expected count is 6.25. Of the 25 participants who identified as "Non-White", 20 reported using ROM within supervision and five did not. Of the 155 participants who identified as "White", 115 reported using ROM within supervision and 40 did not. A phi coefficient was calculated to assess the strength of this relationship, $\Phi = .05$ [.41, .69]. This corresponds to a small effect size. This was not a statistically significant association, χ^2 (1) = .39, $p = .53$). The nature of the relationship indicates that ethnicity did not result in a statistically significant higher proportion of ROM user within supervision. Results for the chi-square test can be found in Table 20.

Table 20

Results of Chi-square Test for Ethnicity and ROM Use

Indicated ROM Use	Ethnicity	
	White	Non-White
Yes	115 (63.89)	20 (11.11)
No	40 (22.22)	5 (2.78)

Note. $\chi^2 = .39$*, $df = 1$, Numbers in parentheses indicate column percentages.
*$p > .02$

Open-Ended Statement Results

The open-ended quantitative data consisted of four separate yet related open-ended questions regarding the utilization of routine outcome monitoring. These were questions 30 ("Describe how you identify treatment non-responders and deteriorating

patients within supervision"), 52 ("Describe what interventions you use to work with non-responders and deteriorating patients within supervision"), 53 ("What is your current understanding of the use of routine outcome measures within supervision"), and 54 ("What are the strengths and weaknesses you see when using routine outcome measures within supervision?") within the survey. It should be noted that each of these open-ended questions are both limited in range and are narrowly centered. In other words, the open-ended results do not stem from in-depth interviews regarding the phenomenon in question, which is typical of more rigorous qualitative studies. Furthermore, the following open-ended statement results do not meet the overall rigor of a qualitative study and should be interpreted accordingly. As an example, responses for questions often consisted of "one word" answers, were left blank, or were brief sentence descriptions. Additionally, participant responses were solicited from an online survey, and therefore, non-verbal behaviors cannot be reported. Although the identified themes appear to represent participant responses, it should be noted that not every theme was represented in each participant response, and therefore the results do not capture everything that participants may have been trying to convey. Despite these limitations, a phenomenological approach to the open-ended statement portion of this study was still determined to be appropriate. The following section provided the description of the open-ended statement analysis process. The data set was analyzed using a version of Bazeley's (2013) approach to phenomenological analysis. This approach is conducted in five steps: 1) the data set is organized by general statements; 2) the data set is examined for central themes that arise out of the responses; 3) The central theme is examined in regard to the study question; 4) Each of the themes are clustered together in an effort to further

understand the essential themes; and 5) the clusters are integrated to yield a description of the study topic that is rooted within the context of the participant's subjective experience.

Step 1, which was conducted by the lead researcher, consisted of organizing the data set by general statements based on the type of responses provided by participants. Upon the completion of this step, results were shared with another researcher who was familiar with the clinical supervision literature base and had received training in qualitative methods. This began the second step of the analysis process, which consisted of investigating the statements for general themes. Using Microsoft Excel Spreadsheets, categories were created based on participant responses and the lead researcher's knowledge and understanding of existing clinical supervision literature. These themes were then shared with aforementioned researcher who had previously reviewed the data. Next, the categories were examined in regard to how supervisors were identifying and responding to non-responsive and deteriorating patients. Additionally, they were examined in regard to current understanding of the use of outcome measures within supervision and why participants may or may not be utilizing routine outcome measures within the context of supervision. Themes resulting from this process were recognized as sub-themes under the main theme categories. The lead researcher conducted this process and shared the preliminary results with the same outside researcher. This examination resulted in step 4, which consisted of refining the themes and producing a comprehensive understanding and grouping of fundamental themes that emerged within the data. Lastly, step 5 consisted of integrating the findings in order to provide a descriptive narrative of the data set being examined. Detailed and thorough notes were taken throughout the process in order to create a clear description of the overall process that could be evaluated

in future research regarding clinical supervision (Bazeley, 2013). The following sections highlight the results of the open-ended statement data and results are depicted in Table 18.

In the following sections, each theme is described and relevant quotations from participants are provided in an effort to further elaborate the underlying meaning within each category. These sections list the open-ended statements and questions, which are in bold, the core themes, which are in bold and the sub-themes, which are italicized.

Statement: "Describe how you identify treatment non-responders and deteriorating patients within supervision."

Core theme 1: Supervisee experiences.

Sub-theme 1a: Verbal reports. Of the 118 participants who chose to complete question 30, 74 indicated that they rely on their supervisee verbal reports. It was determined that the participants were relying on verbal reports of their supervisees based on their responses to question 30. Verbal reports consisted of responses that indicated supervisors were receiving information regarding the patient from processing directly with their supervisee within supervision. Regarding supervisee verbal report, one participant stated that "I listen to my student's comfort level when working with certain patients." Another indicated that "[The] supervisee provides input about clients who are not responding well." A third participate indicated that "All of my supervisees are trained to do a skilled risk assessment, and when an element is increased…. the trainee has been trained already to bring this immediately to my attention…" And yet another participant stated that identification of deteriorating and non-responsive patients is "generally based on the supervisee's report of the situation." Statements such as these

indicated that supervisors may often heavily rely on their supervisee's observations of patients and verbal report during the process of supervision.

Sub-theme 1b: Documentation. Of the 86 participants who indicated that they rely on supervisee experiences to identify non-responsive and deteriorating patients within the context of supervision, 11 indicated that they rely on documentation via the supervisee. Statements such as using "supervisee's case notes which indicate client progress", and "read supervisee's session note" each indicate that supervisors may rely on their supervisee's observations and how their supervisee conveys their experience of patients who may be non-responsive or deteriorating.

Core theme 2: Supervisor clinical judgment.

Sub-theme 2a: Supervisor observations. Of the 57 participants who indicated that they rely on their own clinical judgment in order to identify deteriorating and non-responsive patients. 50 indicated that they rely on supervisor observations such as video/audio review, judgment of documents and knowledge of patients in order to determine the status of patients. One participant stated they "Process supervisee perceptions through parallel process with my clinical judgment." Another stated they identification was "based on clinical judgment and case review as well as review of tape." A third participate indicated that "Sometimes I judge myself from the tone of the note completed by the supervisee." Finally, one participant stated that they "Review cases individually, identify cases with high risk and cases with low responsiveness/lack of responsiveness. The responses indicate that supervisor clinical judgment may be a common and necessary tool in identifying non-responsive and deteriorating patients within the context of supervision.

Sub-theme 2b: Direct inquiry. Seven of the 57 participants who indicated using clinical judgment reported that they use direct inquiry as a tool to identify non-responsive and deteriorating patients. These responses were coded as participants stating specifically that they ask direct questions of their supervisees. One participant indicated that they identify these patients "based on answers to my questions when I don't see the patient making progress." Another participant indicated that "I ask for symptoms noted and verbally expressed." A third participant stated that "At times, I ask which of their cases feels most challenging and which cases they feel 'stuck'." These responses appear to suggest that supervisors identify direct inquiry as a helpful method in identifying patients who are non-responsive or deteriorating.

Core theme 3: Patient indicators.

Sub-theme 3a: Engagement in the therapeutic process. Of the 70 participants who reported that they examine patient indicators as a way of identifying treatment non-responsiveness and deterioration, 27 reported that they examine patient engagement in the therapeutic process. These responses were coded as supervisors specifically looking patient engagement in the therapeutic process, such as but not limited to session attendance and completion of homework. Participant responses which were coded as such consisted of identifying patients as those "who frequently no show or cancel sessions", "reported/demonstrated ambivalence to treatment to meet treatment goals", and "unwillingness to work on goals they initiate." Another participant indicated the "Patient's ability/motivation to participate and respond to treatment. Medication compliance." Lastly, another participant specified "Attendance. Adherence to interventions" as important patient indicators of non-responsiveness. These responses

suggest that patient behaviors pertaining to engagement in therapy are important indicators of potential patient non-responsiveness and deterioration.

Sub-theme 3b: Use of outcome measures/symptom inventories. The most commonly used patient indicator to monitor patient outcome reported by participants were the use of outcome measures (41). One participant stated that they examine "Pre and Post CCAPS scores" while another simply stated "through outcome measures." A third participant indicated "Review of the ORS/SRS tracking graph" as a way to identify non-responsive patients. Lastly, a participant stated that "At our site we don't have a structured way to use outcome measures every session or every four sessions or first-last…however I encourage my supervisees to administer the OQ-45. At times we use symptom inventories that are more targeted to the specific symptoms the client has identified." These results indicate that this group of participants may use a variety of ROM systems to identify deteriorating patients and treatment non-responders.

Sub-theme 3c: Progress in treatment goals. Thirty-one participants indicated that they use progress toward treatment goals as a way to monitor patient deterioration. This theme was expressed through such responses as "review of treatment progress towards objective goals", "acting in line with identified treatment goals via trainee's report of the patient's report" and "not making progress towards goals." This theme suggests the supervisors use treatment goals and the progress within these goals are helpful methods for identifying non-responsiveness and deterioration in patients.

Sub-theme 3d: Verbal feedback. Of the participants who completed question 30, 18 participants indicated that they use verbal feedback as a method for monitoring patient deterioration. These results were coded as participants specifying verbal feedback to

therapists from patients as a method of marking treatment progress. Responses included within this sub-theme include "most central is patient experience of therapeutic alliance" and "patient self-reports of mood and/or symptoms in session." Another participant simply stated "client self-report." Results suggest that feedback directly from the patient within session and conveyed to the supervisor via supervisee may be helpful in the identification of deterioration and non-responsiveness.

Core theme 4: Consultation.

Sub-theme 4a: Consultation with treatment team, outside supervisors. Eighteen participants indicated that they use consultation with other providers as a way of detecting non-responsiveness and deterioration of their supervisee's patients. One participant stated "as needed, consultation with other providers working with that client." Another indicated "by talking with other staff within my supervisee's treatment program." Lastly, another participant stated that they determine non-responsiveness "if other providers give me feedback about a particular patient." It would appear that input from other providers is a helpful tool identified by practicing supervisors.

Statement: "Describe what interventions you use to work with non-responders and deteriorating patients within supervision."

Core theme 1: Practical methods.

Sub-theme 1a: Alter treatment planning. Of the 86 participants who chose to answer question 52, 37 participants indicated that they alter treatment planning in order for their supervisees to better work with non-responsive and deteriorating patients. These results were coded based on responses that indicated alterations to treatment plans and were provided during supervision to implement during session. One participant stated

"changing the theoretical approach" while another stated they use the "application of stages of change model." Another participant indicated "motivational interviewing techniques as well as systems and client centered approaches." A final participant stated "behavioral activation, suicide safety plan." Results indicate that supervisors may provide specific ways of altering treatment to their supervisees and have them incorporate these suggestions into session.

Sub-theme 1b: Processing with patient within session. Twenty-seven participants reported that they encourage their supervisees to process noted difficulties in session with the patients. This code was developed based on participant responses that indicated direct and transparent discussion with patients regarding treatment. One participant indicated "discussing timing of interventions used in session with client." Another participant stated, "I encourage my supervisee to use the therapeutic relationship and the rapport they've built to gently challenge the client." Yet another stated that they "encourage the therapist to discuss the therapeutic process with the client." Lastly, another participant indicated "engage in process conversations. Do the clients think therapy is helping/going well? Is the bond good? Ask these questions and re-evaluate." It would appear a significant portion of supervisors encourage their supervisees to engage in process conversations with patients who may show signs of non-responsiveness or deterioration.

Sub-theme 1c: Basic techniques. Of the participants who chose to answer question 52, 10 indicated the use of basic techniques when working with deteriorating or non-responsive patients. These results were coded based on existing literature that describes basic therapeutic skills used within session (Hill & O'Brien, 1999). One participant stated "refocus on alliance, realignment of goals and methods between therapist and patient."

Another indicated "positive re-enforcement…therapeutic silence, creative hopelessness, consistently provide opportunities to engage." A final participant stated "focusing on rapport…meeting the client where they are." These types of responses appear to suggest that these supervisors encourage the use of basic therapeutic techniques when supervisees are working with non-responsive and deteriorating patients.

Sub-theme 1d: Referral. Twenty-one participants indicated that they use referral as a method of working with deteriorating and non-responsive patients. Coding for these results pertained to responses that consisted of referrals to medical, mental health, or alternative modalities. One participant cited "referral for med consult; referral to higher level of care or private practitioner in the community." Two indicated that they would refer to an alternative modality ("Sometime bibliotherapy or alternative medics referrals can get patients unstuck" and "Referral to DBT group"). Two others suggested referrals to psychiatric and higher levels of care ("Refer to clinical round or medical staff (i.e. other experts)" and "Referral to psychiatric provider…to higher level of care such as partial hospitalization or inpatient hospitalization." Results indicate that a significant portion of supervisors who responded to question 52 rely on referral to other providers as a way to address their supervisees non-responsive and deteriorating patients

Core theme 2: Conceptual methods.

Sub-theme 2a: Reconceptualization of treatment. Fourteen participants indicated that they would have their supervisee's re-conceptualize treatment, diagnoses and other factors related to patient care. Two participants stated a focus on conceptualization, as noted by "step back and look at the conceptualization, treatment goals and how they are responding" and "Focus on case conceptualization (or, reconceptualization), with the

addition of any new information gained thus far; this often leads to recommitment to a specific principle of change, or shift to more appropriate principle." Another participant indicated "It can help to take a step back and see the ups and downs in the big picture." Lastly, a participant stated "we review case conceptualization specifically related to intervention being used or a chalkboard case conceptualization, and how the conceptualization is driving the treatment and what changes need to be made." These responses indicate that some supervisors may find the reconceptualization of patient care as an important part of working with non-responsive or deteriorating patients.

Sub-theme 2b: Process with supervisee. Sixteen participants stated that they process with their supervisee as a way of addressing deteriorating and non-responsive patients within the context of supervision. These results were coded as specific responses pertaining to speaking directly with supervisees in order to address various aspects of treatment, parallel processes and personal reactions. One participant stated they "process internal struggles" with their supervisor. Another reported that they "identify barriers to engagement in treatment" and yet another stated "I work hard for the therapist to not personalize this sort of client." A final participant indicated "discussing parallel process" as one way of working with supervisees to address non-responsive and deteriorating patients. Reponses indicate that processing difficulties with supervisees may be helpful in working with treatment non-responders.

Sub-theme 2c: Consultation. Of the participants who answered question 52, 11 indicated that they utilize consultation as a method for working with patients who are unresponsive to treatment. One participant indicated that they "seek feedback from other licensed professionals through consultation and supervision of supervision." Another

stated "Consult with other specialist/supervisors." One participant simply stated "Consultation." These results suggest that supervisors may utilize additional consultation when working with treatment non-responders within the context of supervision.

Core theme 3: Other.

Sub-theme 3a: No experience. Two participants stated that they had no experience working with non-responsive patients within the process of supervision. One participant writes "Luckily, the students that I have supervised have not had this experience." The other simply states "No experience with supervisees on this." These results suggest that these participants have not worked with deteriorating or non-responsive patients within supervision.

Question: "What is your current understanding of routine outcome measures and supervision?"

Core theme 1: General description.

Sub-theme 1a: Definition/description of use. Two participants indicated a general understanding of the use of routine outcome measures. One of the participants simply stated "identify and work with deteriorating clients." The other participant responded to the prompt with a definition, and stated "Standard screening tools are administered during the intake and rescreened on a regular basis. The change in the score from intake to discharge represents an outcome measure." These responses indicate these participants have at least some knowledge of the purpose and description of routing outcome measures.

Core theme 2: Purpose of use.

Sub-theme 2a: Providing context. Of the 103 participants who answered question 53, 24 indicated that they use routine outcome measures within supervision to provide context to treatment of non-responsive and deteriorating patients. These results were coded by looking at responses that indicated ROM provided a larger or overall understanding as to where patients within the course of treatment. One participant remarked "We use them as part of creating an overall picture of the work and client presentation." Another stated "I feel they are necessary because otherwise the supervisor is relying on the supervisees' interpretation of what is going on." Another response indicated that "They can be a valuable tool if the supervisee seems unable to provide accurate information regarding current client status." A third stated "Using outcome measures would be an objective way to understand where the patient is, rather than depending on the student's conceptualization." A final participant remarked "They can be helpful to identify major changes in functioning that a patient may not be initially forthcoming to tell (sexual functioning, suicidality, etc.)." These responses indicate that supervisors may find value in the use of ROM during supervision, and that it provides additional information to the understanding of the patient and treatment progress.

Sub-theme 2b: Prompt to alter interventions. Seven participants indicated that they understand routine outcome measures within supervision as a tool to prompt supervisees to alter interventions. One participant stated "adjust the treatment plan when there are non-responders or patient's who deteriorate is essential." A second participant indicated "Use of routine outcome measures allow feedback to assist the supervisee regarding process, effective interventions and assist in engagement discussion with

clients." A final participant stated "Can be helpful to discuss and use in treatment planning and goal setting." Results suggest that these supervisors may use routine outcome measures as a way of prompting changes within treatment.

Sub-theme 2c: Effective supervision/treatment. Of the participants who answered question 53, 10 indicated they use ROM to measure the effectiveness of supervision and treatment. One participant remarked that they used routine outcome measures to "offer opportunities to discuss how treatment is going." A second participant stated, "They can be a useful tool to explore efficacy and provide another measure of therapy success." Another participant stated that they use routine outcome measures to monitor supervision effectiveness (i.e. "tells how effective supervision is."). An additional participant stated, "I understand that it could have a positive impact on the supervision relationship." These results suggest that this group of supervisors may use ROM as a way to measure the effectiveness of therapy and supervision.

Core theme 3: Non-specific indicator.

Sub-theme 3a: Helpful. Thirteen participants indicated that they believe the use of ROM within supervision is helpful. One participant reported, "they offer a rich source of data and are quite beneficial" while another simply stated "they are helpful." A third participant indicated, "they can be useful if the supervisee will use them correctly." These results suggest that this group of supervisors find the use of ROM useful within the context of supervision.

Sub-theme 3b: Unhelpful. Four participants reported that they believe that the use of ROM within supervision is unhelpful. One participant stated, "I feel like outcome measures are a flavor of the month that are being overused. They direct the therapist

away from the interpersonal process and encourage clients to communicate through questionnaires rather than more directly." Another participant responded, "I understand that some supervisors ask their supervisees to use routine outcome measures. I do not because I have yet to find a routine outcome measures that is meaningful." These results suggest that this group of supervisors may not find the use of ROM within supervision as helpful.

Sub-theme 3c: Is used. Three participants simply stated that they understand that routine outcome measures are used within the context of supervision. One participant stated they, "use them regularly, especially for traditional therapies (versus primarily psychoeducational approaches)." Another participant responded, "I use them at the halfway point and at the conclusion of the rotation." These results suggest that this group of supervisors use ROM within the context of supervision.

Core theme 4: Not used.

Sub-theme 4a: Not used within supervision. Eight participants indicated that they do not use routine outcome measures within supervision. Two participants reported that they do not use them within their primary placement ("I have respect for the use of them, but it hasn't been a tool in my practice" and "We do not use them within our facility."). Two other participants simply stated "I do not use them." Specific reasons for the lack of use of ROM systems was not specified in any response.

Core theme 5: No understanding.

Sub-theme 5a: No Understanding/Unknown/Unsure. Of the 103 participants who answered question 53, 6 participants indicated that they had no understanding or were unsure of what the use of routine outcome measures within the context of supervision

entailed. These results consisted of responses such as, "I do not currently have any understanding", "None", and "Unknown." Simply stated, these results suggest that this group of supervisors have limited to no understanding of the use of ROM systems within the context of supervision.

Regarding the following section, the results following question 54 centered around two general categories, in which responses related to the use of routine outcome measures within supervision were separated into strengths and weaknesses. Following the aforementioned process, findings within this question are further organized into their core themes based on responses provided as to the strengths and weaknesses of the use of routine outcome measures within supervision.

Question: "What are the strengths you see when using routine outcome measures within supervision?"

Core theme 1: Pro resources.

Sub-theme 1a: Time/ease of use. Of the 97 participants who chose to answer question 54, 6 participants indicated that routine outcome measures were fast and easy to use. One participant stated, "quick way to assess multiple symptoms, quick ways to assess critical questions." A second participant stated, "Outcomes are easy to administer and track." A third participant indicated, "Strengths have been—ability to have client complete measure at home/by email…" while an additional participant indicated that routine outcome measures are "easily reviewed." These responses suggest that the use of ROM may be a fast and easy way to collect patient information that contains valuable information that is useful within supervision.

Core theme 2: Pro objective.

Sub-theme 2a: Objective/reliable. Eleven participants who chose to answer question 54 indicated that the use of routine outcome measures is an objective and reliable way of collecting information for use within supervision. One participant responded, "Outcome measures are more objective" while a second participant stated, "an objective measure of success rather than simply clinical judgment." A third participant response stated, "A strength is that it allows one to compare clinical observations to the symptoms that the measure captures, and plot these across time." While another participant responded to saying that the use of routine outcome measures is, "more objective than interviewing patient." A final participant remarked that ROM systems were a, "Strength: It is the only true reliable means of evaluating change." These responses indicate that this group of supervisors found the use of ROM to be an objective and reliable tool within the context of supervision.

Sub-theme 2b: Empirical. Nine participants stated that they found the empirical nature of ROM systems to be a strength of their use. These results were coded by looking at responses that contained specific references to ROM systems being empirically or psychometrically based. One participant stated, "Pro: Evidence-Based and clear interventions." A second participant indicated ROM systems use was an, "outside empirical perspective on client outcome." A final participant named ROM use within supervision as, "empirical support for treatment efficacy." These results suggest that this group of supervisors find the empiricism of ROM use as a strength to their use within supervision.

Core theme 3: Pro clinical indicator.

Sub-theme 3a: Alternative source of information. Twenty-seven participants who chose to answer question 54 indicated that they found the use of routine outcome measures as a beneficial source of alternative information helpful to the supervisee within the therapeutic process. One participant stated, "One strength is that it can identify issues a supervisee is not directly asking/addressing." A second participant indicated that, "I think they can be useful in providing additional data, and that we can use that data to further shape and improve the work." Another stated the use of routine outcome measures have the, "ability to inform treatment with new clinical information." Yet another participant reported that it, "may help some clients give voice to concerns….may help a supervisee catch a concern that might not have seen." A final participant notes, "I think is a helpful way to assess a perceived reduction in symptoms from a patient's perspective and can guide treatment." These results appear to suggest that this group of supervisors view the use of routine outcome measures as a helpful way of gathering additional information about supervisee patients.

Sub-theme 3b: Tracking change. Of the 97 participants who chose to answer question 54, 27 indicated that they see tracking patient change as a strength of the use of routine outcome measures. One participant remarks their use "helps patient to see progress and therapist to monitor progress." A second participate indicated that the use of routine outcome measures may, "alert the clinician to possible serious problems that need to be addressed immediately." Another participant writes it allows to, "have an idea where the patient is." A fourth participant stated that it, "normalizes discussions of progress (or lack of) in supervision and within the therapy relationship." A final

participant simply stated that the use of routine outcome measures facilitates, "better tracking." These results indicate that this group of participants view ROM system's ability to monitor patient change as strength of its use.

Sub-theme 3c: Supervisee growth. Five participants indicated that they found the use of routine outcome measures to be useful in supervisee training and monitoring supervisee growth. These results were coded by looking at responses that specified supervisee training needs as a strength of the use of routine outcome measures within the process of supervision. These results were reflected in statements such as, "This can be an indicator of the supervisee's progress in working with clients" and, "essential to assess knowledge and growth in core competencies." A second participant remarked, "We can see if the clinician's clinical judgment is inline with the outcome measures." Another participant stated, "it can provide novel therapists with direct data of how client's are doing and can help facilitate reflection." A final participant indicated that the use of routine outcome measures could be used in, "improving supervision and identifying growth edges." These statements suggest that this group of supervisors view routine outcome measures within supervision as a strength of their use.

Question: "What are the weaknesses you see when using routine outcome measures within supervision?"

Core theme 1: Con resources.

Sub-theme 1a: Time. Seventeen participants indicated that they viewed the amount of time needed to administer ROM systems as a weakness of their use. One participant stated, "The only challenges I see, are that administering the measures adds another task/hurdle to the already busy clinicians…." A second participant remarked,

"Therapists do not want to take up the therapy time to re-administer the tool." A third indicated that one would, "have to balance the value with the time it takes patients to compete them." Another participant remarked that it takes time to teach supervisee's how to appropriately use ROM systems, reflected in their statement of, "sometimes it is a bit of work to teach them how to score and interpret." Five participants simply stated that ROM systems are, "time consuming." These results indicate that this group of supervisors may be less likely to utilize ROM systems within their supervision due to the length of time it may take to administer the measures to patients.

Sub-theme 1b: Expenses. Three participants stated that they viewed the cost of ROM systems as a weakness of their use. Responses such as, "Weakness is time and cost", "barriers include ability to obtain certain measures" and simply, "expensive" each suggest that this group of participants view the cost and expense of using ROM systems as a weakness of their use.

Core theme 2: Therapeutic impact.

Sub-theme 2a: Overreliance. Eleven participants who chose to answer question 54 indicated that supervisee over-reliance on the measure was a significant weakness of the use of ROM systems. One participant remarked, "Weakness can be over-reliance (i.e., supervisee is only focused on symptom reduction…)." Another participant echoed a similar sentiment, shown by their statement of, "Weakness include being caught up with a 'number' or hyper-focused on the OQ in session…" A third participant indicated, "You are focused on details and not what is going on in the therapy." A final participant stated that the use of ROM systems can result in an, "over-reliance on quantitative v. quantitative/qualitative balance." These results indicate that this group of supervisors

may find supervisee over-reliance on ROM systems as a weakness and have potential negative impacts on therapeutic work.

Sub-theme 2b: Impact on relationship. Of the 97 participants who chose to answer question 54, 11 stated that they felt the use of ROM may have a negative impact on the therapeutic and/or supervisory relationship and indicated this reason as a weakness of its use. One participant remarked, "May impact the supervisory relationship with the supervisee thinking that the supervisor does not trust their clinical judgment." Another indicated, "may not attend to the therapeutic relationship." A third participant stated that ROM systems, "are impersonal and don't always speak to specific client goals." Another participant stated that, "The downfall is that it is highly face valid, and some supervisees may feel pressure to say the 'right' answer to avoid ruptures in the supervisory relationship." A final participant remarked that using ROM systems, "…could alter the therapeutic relationship to do so." These responses suggest that this group of supervisors feel that a weakness of ROM system use maybe it's potential to disrupt or negatively impact the therapeutic or supervisory relationship.

Core theme 3: Unreliable.

Sub-theme 3a: Not assessing true change. Twenty-five participants stated that a weakness of ROM system use was that they were unable to accurately assess true change in the therapeutic and supervisory relationship. These results were coded by examining responses that discussed aspects that may alter outcome results (e.g. re-test bias, over-reporting, under-reporting). These results were expressed through responses such as, "in a university setting, some students are heavily influenced by the ebb and flow of the semester (i.e. drop in presentation during finals) which impacts the outcome in ways that

don't tell the whole story." A second participant wrote that ROM systems, "do not necessarily reflect improvement/decline and real-world changes." And yet another remarked, "decreased measurement reliability due to repeated exposures." A fourth participant described the use of ROM systems as an, "objective report not matching subjective experience. Over/Under reporting symptoms due to secondary gain." Another remarked, "Patients can get tired of filling them out and just put rote answers rather than a true depiction of psychological state." A final participant stated, "A weakness is that it is difficult to tease out whether their responses are due to environmental factors (e.g., having a good day)." These results suggest that this group of supervisors may feel that ROM systems may not be a true reflection of change when used with patients.

Sub-theme 3b: Not appropriate. Eleven participants of the 97 who chose to answer question 54 indicated that they felt like the use of ROM systems was not always appropriate. These results were coded based on responses that indicated that the use of ROM systems might not be an appropriate tool for use with patients or within supervision. These results were noted in such responses such as, "I've been looking into using outcome measures and one issue I'm running into is that the population I (and my supervisees) work with tends to be subclinical, and many measures have limited usefulness for this population." Two participants noted weakness in its use due to cultural concerns (e.g. "not culturally appropriate" and "not always culturally sound." Another participant stated, "They don't really measure anything that is meaningful. They force clients to fit our image of being a successful therapist but really tell us nothing about how the client is changing. No doubt they generate a lot of research but I don't see them as clinically useful. I think they just create illusions that the therapist is having an effect on

the client." And another participant indicated they, "question the applicability to all clients; for example, CCAPS 34 not as sensitive to eating disordered clients and some clients react w/ great shame when their profiles do not significantly change." A sixth participant indicated, "they are difficult to use in our population, because many of our patients either are not able to complete them due to mental illness or will not complete them." These results suggest that this group of supervisors find a weakness of ROM system use to be that they are inappropriate with some populations.

Sub-theme 3c: Not used appropriately. Eighteen of the participants indicated that they felt a weakness of routine outcome measures was that they are not always used appropriately. This code is reflected in statements such as, "The tools are administered but not interpreted and/or incorporated into treatment." A second participant remarked that it's, "important to go beyond the outcome measure. Not helpful if you address only the score." Another participant indicated, "supervisees may over-interpret small changes in scores." A fourth participant stated, "Not everyone understand their purpose. They are not always used to gage process/looked at all." Another participant indicated that, "I don't always remember to review the numbers." One participant noted that, "There is a wide variability in the use of these by patient and/or condition when it is part of the systematic process of a clinic, leading to spotty use and benefit." A final participant stated, "I think that a weakness can be when people assume that measures represent the only meaningful data, or the only outcomes worth aiming for." Results from these participants suggest that this group of supervisors view limited understanding or inappropriate use of ROM systems as a noted weakness of their use within the supervision process.

Sub-theme 3d: Unhelpful. The remaining participants (7) who provided responses to this item suggested that they found the use of ROM systems to be unhelpful both therapeutically and within the supervisory process. These results were reflected in responses such as, "ROM data is not valid for maybe 20% of patients…" and, "Not always helpful to the supervision process", though these comments failed to specify how or why ROM systems use may not be helpful. A final participant remarked, "Deteriorating or stagnant scores may indicate that the treatment isn't right for the patient, that the patient isn't doing their part, or that the therapeutic relationship is poor. These measures do little to answer these questions." These results indicate that this group of participants views the use of ROM systems as unhelpful therapeutically and within supervision, and thus, is a noted weakness. The results of this analysis can be found in Table 21.

Table 21: Open-ended Statement Results

Statement 1:	
Describe how you identify treatment non-responders and deteriorating patients within supervision.	
Core Theme 1:	
Supervisee Experiences	
Subthemes:	Example:
Verbal Reports (74)	"Generally based on the supervisee's report of the situation"
Documentation (11)	"Supervisee's case notes which indicates client progress."

Table 21 cont.

Core Theme 2:	
Supervisor Clinical Judgment	
Subthemes:	Example:
Supervisor Observations (50)	"Review cases individually, identify cases with high risk and cases with low responsiveness/lack or responsiveness."
Direct Inquiry (7)	"I ask which of their cases feels most challenging and which cases they feel 'stuck'."
Core Theme 3:	
Patient Indicators	
Subthemes:	Example:
Engagement in the Therapeutic Process (27)	"Unwillingness to work on goals they initiate."
Use of Outcome Measures/Symptom Inventories (41)	"At our site we don't have a structured way to use outcome measures every session or every four sessions or first-last…however I encourage my supervisees to administer the OQ-45. At times we use symptom inventories that are more targeted to the specific symptoms the client has identified."
Progress in Treatment Goals (31)	"Not making progress towards goals."
Verbal Feedback (18)	"Patient self-reports of mood and/or symptoms in session."

Table 21 cont.

Core Theme 4:	
Consultation	
Subthemes:	Example:
Consultation with treatment team/outside supervisors (18)	"Consultation with other providers working with that client."
Statement 2:	
Describe what interventions you use to work with non-responders and deteriorating patients within supervision.	
Core Theme 1:	
Practical Methods	
Subthemes:	Example:
Alter Treatment Planning (37)	"Changing the theoretical approach."
Processing with Patient within Session (27)	"Engage in process conversations. Do the clients think therapy is helping/going well? Is the bond good? Ask these questions and evaluate."
Basic Techniques (10)	"Positive re-enforcement…therapeutic silence, creative hopelessness, consistently provide opportunities to engage."
Referral (21)	"Referral for med consult, referral to higher level of care of private practitioner in the community."
Core Theme 2:	
Conceptual Methods	
Subthemes:	Example:
Reconceptualization of Treatment (14)	"Focus on case conceptualizations (or, reconceptualization), with the addition of any new information gained thus far; this often leads to recommitment to a specific principle of change, of shift to more appropriate principle."

Table 21 cont.

Process with Supervisee (16)	"Process internal struggles."
Consultation (11)	"Seek feedback from other licensed professionals through consultation and supervision of supervision."
Core Theme 3:	
Other	
Subthemes:	Example:
No Experience (2)	"Luckily, the students that I have supervised have not had this experience."
Question 3:	
What is your current understanding of routine outcome measures and supervision?	
Core Theme 1:	
General Definition	
Subthemes:	Example:
Definition/Description of Use (2)	"Standard screening tools are administered during the intake and rescreened on a regular basis. The change in the score from intake to discharge represents an outcome measure."
Core Theme 2:	
Purpose of Use	
Subthemes:	Example:
Providing Context (24)	"We use them as part of creating an overall picture of the work and client presentation."
Prompt to Alter Interventions (7)	"Can be helpful to discuss and use in treatment planning and goal setting."
Effective Supervision/Treatment (10)	"Tells how effective supervision is."

Table 21 cont.

Core Theme 3:	
Non-Specific Indicator	
Subthemes:	Example:
Helpful (13)	"They offer a rich source of data and are quite beneficial."
Unhelpful (4)	"I feel like outcome measures are a flavor of the month that are being overused. They direct the therapist away from the interpersonal process and encourage clients to communicate through questionnaires rather than more directly."
Is Used (3)	"I use them at the halfway point and at the conclusion of the rotation."
Core Theme 4:	
Not Used	
Subthemes:	Example:
Not Used Within Supervision (8)	"I have respect for the use of them, but it hasn't been a tool in my practice."
Core Theme 5:	
No Understanding	
Subthemes:	Example:
No Understanding/Unknown/Unsure (6)	"I do not currently have any understanding"

Table 21 cont.

Question 4a:	
What are the strengths you see when using routine outcome measures within supervision?	
Core Theme 1:	
Pro Resources	
Subthemes:	Example:
Time/Ease of Use (6)	"Quick was to assess multiple symptoms, quick was to assess critical questions."
Core Theme 2:	
Pro Objective	
Subthemes:	Example:
Objective/Reliable (11)	"An objective measure of success rather than simply clinical judgment."
Empirical (9)	"Empirical support for treatment efficacy."
Core Theme 3:	
Pro Clinical Indicator	
Subthemes:	Example:
Alternative Source of Information (27)	"I think they can be useful in providing additional data, and that we can use that data to further shape and improve the work."
Tracking Change (27)	"Helps patient to see progress and therapist to monitor progress."
Supervisee Growth (5)	"This can be an indicator of the supervisee's progress in working with clients."

Table 21 cont.

Question 4b:	
What are the weaknesses you see when using routing outcome measures within supervision?	
Core Theme 1:	
Con Resources	
Subthemes:	Example:
Time (17)	"The only challenges I see, are that administering the measures adds another task/hurdle to the already busy clinicians."
Expenses (3)	"Expensive."
Core Theme 2:	
Therapeutic Impact	
Subthemes:	Example:
Overreliance (11)	"Weakness can be over-reliance (i.e. supervisee is only focused on symptom reduction."
Impact on Relationship (11)	"May impact the supervisory relationship with the supervisee thinking that the supervisor does not trust their clinical judgment."
Core Theme 3:	
Unreliable	
Subthemes:	Example:
Not Assessing True Change (25)	"Do not necessarily reflect improvement/decline and real-world changes."
Not Appropriate (11)	"I've been looking into the use of outcome measures and one issue I'm running into that the population I (and my supervisees) work with tends to be sub-clinical, and many measures have limited usefulness for this population."
Not Used Appropriately (18)	"The tools are administered but not interpreted and/or incorporated into treatment."

Table 21 cont.

Unhelpful (7)	"Deteriorating or stagnant scores may indicate that the treatment isn't right for the patient, that the patient isn't doing their part, or that the therapeutic relationship is poor. These measures do little to answer these questions."

Chapter 6 Discussion

"Knowledge is of no value unless you put it into practice."
-Anton Chekhov

The purpose of this study was to explore how supervisors currently identify the patients of supervisees who are unresponsive to treatment, how supervisors work with these patients within the context of supervision and the impact of regulatory focus on the use or non-use of ROM within supervision. Several hypotheses were suggested in order to examine methods of supervisors, as well as overall use or non-use of ROM systems within the context of supervision. These hypotheses were developed based on existing literature and were designed in an attempt to obtain information that would be considered useful to practicing supervisors and the supervisory process. The following sections will attempt to highlight the findings, with the results being organized into two sections. The first will section will discuss the current methods of practicing supervisors and the significance of these findings. The second section will discuss ROM use versus non-use among supervisors, with headings to denote specific results.

Methods of Practicing Supervisors

Currently, there is no existing information about the methods of practicing supervisors in response to deteriorating and non-responsive patients, despite an emphasis in the supervision literature that a supervisor's primary responsibility is to ensure patient welfare by means of a positive treatment outcome (Ellis & Ladnay, 1997). In other words, there is very little we know about how currently practicing supervisors identify and respond to non-responsive and deteriorating patients within the process of supervision. As such, it would appear difficult to determine how supervisors uphold ensuring patient welfare given that there is no information on how supervisors identify

non-responsive or deteriorating patients, nor is there information regarding their course of action once these patients have been identified. Given the lack of research on this topic, the results of this study will provide a necessary addition to the existing literature, and may ultimately lead to positive changes within the practice of supervision in regard to ensuring patient welfare.

When considering the findings of how supervisors *identify* non-responsive and deteriorating patients, it is interesting to note both the highest and lowest endorsed responses from the survey. For example, in response to the question "How do you identify treatment non-responders in supervision?" the most frequently endorsed responses included, from highest to lowest: "I rely on my own clinical judgment" (*M*= 3.39), "I rely on my supervisee to identify patients who experience high levels of symptom distress" (*M* = 2.93), "I rely on my supervisee to facilitate feedback from the patient during session" (*M* = 2.88), and "I rely on my supervisee's clinical judgment" (*M* = 2.82). In other words, the most commonly used method of identifying treatment non-responders is reliance on clinical judgment, whether supervisor or supervisee. The lowest endorsed items included, from highest to lowest: "I rely on video/audio tape/live supervision" (*M* = 2.34), "I rely on outcome measures or symptom inventories (e.g. OQ, CCAPS, etc.) used by my supervisee" (*M* = 2.24) and "I rely on my supervisee's patient to provide unsolicited feedback about how they feel the course of therapy is going" (*M* = 2.08).

These results appear to be notable for several reasons: Firstly, existing literature has revealed that most clinicians, even those who are well trained and more experienced, have a difficult time identifying patients who are non-responsive (Hannan et al., 2005;

Hatfield et al., 2010). Secondly, tangible methods of identifying treatment non-responders have been found to be superior to clinical judgment (Hatfield et al., 2010), and lastly, the use of ROM systems have already been shown to be an effective tool in identifying patients who may experience poor outcome (Hatfield & Ogles, 2006; Lambert et al., 2002). Furthermore, based on this literature, it would seem practical to apply these methods within supervision.

To reiterate, Lambert and colleagues (2002) conducted a meta-analyses of three studies that examined the OQ system. These results showed that the use of patient feedback reduced deterioration by 4-8%, in addition to increasing positive outcomes. Further studies have shown that the use of other ROM systems (PCOMS, CORE-OM, CCAPS) has also been significantly effective at reducing deterioration rates and increasing positive outcome (Barkham et al., 2005; Lambert et al., 2001; McAleavey et al., 2012). Additionally, Shimokawa and colleagues (2010) conducted a meta-analysis of the OQ system in order to replicate these findings, and unsurprisingly, showed that the ongoing use of patient feedback and the OQ-45 significantly improved outcome (Shimokawa et al., 2010). In other words, the use of patient feedback and ROM systems has been shown to increase positive outcome while reducing deterioration rates, yet it appears that supervisors are not utilizing these tools within supervision. Overall, it appears that supervisors are currently more likely to use methods that are contraindicated by existing research (e.g. clinical judgment) and are less likely to use methods that have been shown to be accurate and efficient tools when attempting to identify treatment non-responders (e.g. ROM systems).

The open-ended statement findings echo the above results, with 142 of the responses indicating that supervisors rely on either their supervisee's experiences of the patient or their own clinical judgment in order to identify treatment non-responders. In contrast, only 41 responses suggested that they used ROM as a method for identifying non-responsive patients; even so, responses implied that they were not used on a regular basis ("We don't have a structured way to use outcome measures every session or every four sessions, or first-last…"). Moreover, it is interesting to note that while 60.22% of respondents indicated that the ROM systems are used at their current placement, they reported that it was used within supervision, on average "sometimes" ($M = 2.24$). Put in another way, despite its use within the majority of participants' primary placement and the majority of supervisors indicating their use of ROM systems, it appears that it is not utilized regularly within the process of supervision. Moreover, given that the use of ROM has been shown to be effective in increasing positive outcome and decreasing deterioration, it is interesting to note that this tool is not being utilized as frequently as one might expect. This begs the question as to why ROM systems are not currently being used regularly within supervision, a topic which will be explored and discussed in a later section.

When considering the findings related to how supervisors *respond* to non-responsive or deteriorating patients within the process of supervision, it is again informative to note the highest and lowest endorsed responses to the question "how do you respond to treatment non-responders in supervision?" The most frequently endorsed items, from highest to lowest included "I encourage my supervisee to routinely discuss these patients in supervision" ($M = 3.61$), "I facilitate discussion with my supervisee

about these patients in supervision" ($M = 3.53$), "I have my supervisee attend to the therapeutic relationship" ($M = 3.41$), "I encourage my supervisee reevaluate treatment goals and tasks" ($M = 3.16$) and "I have my supervisee respond to the patient using their best clinical judgment" ($M = 3.12$). In summary, supervisors appear to respond to non-responsive patients by discussing them in supervision and relying on supervisee intervention.

The lowest endorsed items, from highest to lowest, included I encourage my supervisee to seek consultation with another supervisor" ($M = 2.14$), "I encourage my supervisee to refer patients to an alternate treatment modality" ($M = 2.13$), "I encourage my supervisee to re-consider the current diagnosis" ($M = 2.13$), and "I have my supervisee refer patients to another clinician" ($M = 1.81$). Stated differently, the lowest endorsed items were themed around directing patients to other methods of care/consultation.

In terms of actions taken, supervisor's most frequently endorsed responses of how they respond to non-responsive patients appear to coincide with existing literature pertaining to common methods used within psychotherapy. A focus on common factors (goals, tasks and bond), and attendance to the therapeutic alliance, which were two of the most frequently endorsed responses, have been shown in the literature to have a positive impact on patient outcome (Hofmann & Barlow, 2014; Orlinsky et al., 1994). However, it is interesting to note the highest endorsed item of "I encourage my supervisee to routinely discuss these patients in supervision" ($M = 3.61$). As mentioned in the previous section, current techniques used by supervisors in identifying deteriorating and non-responsive patients appear to be less than ideal, and the methods being used are contraindicated by

the existing literature (Hannan et al., 2005; Hatfield et al., 2010; Shimokawa et al., 2010). If supervisors are unable to adequately identify their supervisee's non-responsive patients, though they may be open to discussing these patients within supervision, most if not all non-responsive or deteriorating patients will be overlooked. Furthermore, if supervisors and supervisees are not using actuarial methods to identify non-responders (e.g. ROM systems), it may be difficult to determine if patients are actually responding to changes made within a session (e.g. focus on therapeutic alliance, re-evaluation of treatment goals, etc.). Given these discrepancies, it would seem important to begin implementing effective methods to identify these patients. Moreover, results indicating that supervisors frequently ($M = 3.12$) have their supervisees respond to non-responsive patients using the supervisee's clinical judgment. This is also interesting to note, given that previous research suggests that identifying and responding to deteriorating patients often requires a higher level of self-awareness and reflective contemplation on part of the clinician (Bager-Charleston, 2010). It may be assumed that supervisees who are new to clinical work may not possess this level of self-awareness, and therefore may have difficulty ensuring the best possible outcome for their patients without external guidance.

Three of the four lowest endorsed items pertained to consulting with, or referring patients to other providers. These results suggest that there may be reluctance among supervisors to suggest or have their supervisees transfer care or consult with other providers. These findings are supported within the open-ended statement results, where only 21 participants indicated that they would use referral as a method of working with deteriorating and non-responsive patients. These results are concerning, based on previous research conducted by Walfish and colleagues (2012) and Dexter (2017). In

their research, Walfish and colleagues explored perceptions of clinical judgment of mental health providers. Results from their study indicated that 25% of mental health professionals believed themselves to be in the 90th percentile in comparison to others in their field. In other words, mental health providers appeared to underestimate their rates of deterioration and overestimate their rates of positive outcome (Walfish et al., 2012). Given the results, it would seem that supervisor's may potentially also fall into the flawed belief that they are "better therapists" or "better supervisors" than their peers. This may make them less likely to have their supervisees refer out non-responsive or deteriorating patients or encourage their supervisees to seek out consultation from other providers. As such, it may limit supervisor responsiveness to deteriorating or non-responsive patients.

Results from this self-report study suggest supervisors are also responding to treatment non-responders in ways that are indicated by the literature. One of the lowest endorsed items in how supervisors respond to non-responsive or deteriorating patients within the process of supervision was altering the diagnosis of supervisee patients. This response coincides with existing literature that states diagnosis is not as important to treatment and thus is not as important to treatment planning (APA, 2012). Furthermore, it has been argued that psychiatric diagnoses do not aid in treatment decisions and are not clinically useful (Timimi, 2014). The findings of this study indicate that supervisors are less likely to re-examine diagnosis with their supervisee when working with non-responsive patients, aligning with current research and literature within the field.

Supervisor Characteristics and ROM Use vs. Non-Use

In order to examine ROM use versus non-use among the sample (N =181), a series of chi-square and one-way ANOVA's were conducted to determine if there was a

statistical difference between the use or lack of use of ROM systems and supervisor characteristics. As predicted, results suggested that there is no significant difference between ROM use/non-use and supervisor characteristics (e.g. degree type, supervisory style, number of supervision courses, years since graduate school, years practicing psychotherapy, and years practicing supervision). Given these results, it would appear that the majority of supervisor characteristics are not influential in the use or non-use of ROM within supervision. It is interesting to note that there was a significant difference found in ROM use and theoretical orientation. Based on visual inspection of the chi-square analysis it would appear that behavioral/CBT and eclectic/integrationist are the most likely to use ROM systems within supervision versus other orientations. These results match current literature, which discusses CBT approaches and the use of ROM. An article by Levine and colleagues (2017) argues ROM use fits cognitive-behavioral approaches due to ROM's place as an evidenced based approach to treatment and it's association with environmental factors and behaviors (Levine et al., 2017). Additionally, researchers argue that CBT can be conceptualized through evidenced-based hypotheses, which can be tested and examined through clinical intervention and can therefore be monitored via ROM systems in order to gage progress (Levine et al., 2017). Given these arguments, it would seem that differences in ROM use would be seen between different orientations, however further research is recommended to determine the reliability and strength of these relationships.

Supervisor Characteristics and Primary Placement

Another area of interest within this study was to examine the influence of supervisory characteristics and its influence on primary placement. In order to explore

this relationship, a series of chi-square tests and one-way ANOVAs were conducted. As predicted, results suggested that there was no significant difference between supervisor characteristics (supervisory style, number of supervision courses, years since graduate school, years practicing psychotherapy, and years practicing supervision) and primary placement. Looking at these results, it would appear that the majority of supervisor characteristics are not indicative of where participants reported their primary placement. A related point to consider is that there was a significant difference between degree type and primary placement. Based on visual inspection of the chi-square analysis, it would seem that individuals holding doctoral degrees are more likely to report primary care/hospital/inpatient/residential as their primary placement. This may be a result of sampling characteristics unique to supervisors, such as supervisors may be more likely to hold terminal degrees than the wider population of psychotherapists and supervisors would be more likely found in settings where there are other mid-level providers. In other words, individuals who hold master's degrees may be less likely to be supervisors and those who hold terminal degrees are more likely to be supervisors in agency settings as opposed to private practice.

Regulatory Focus and ROM Use vs. Non-Use

One of the main purposes of this study was to examine the relationship, if any, between placement on the Regulatory Focus Scale and the use or non-use of ROM within supervision. Previous research has suggested that individuals who were more prevention-oriented, in other words, had stronger motivation to avoid failure, would have a more positive outlook on the use of outcome measures (De Jong & De Goede, 2015). These findings suggested that prevention focused individuals would likely be more open to

receiving feedback and using ROM systems to monitor patient outcome. Based on these findings, this study centered its hypothesis regarding regulatory focus on the assumption that supervisors who fell more on the prevention scale would be more likely to utilize ROM within supervision. Interestingly, results indicated that a decrease in promotion score, regardless of prevention score, was a predictor of ROM use within supervision.

Originally, a chi-square test was conducted on the sample (N = 181) in order to identify if a significant difference existed between ROM use and regulatory focus. Forty-seven of the participants identified as bring prevention focused, three participants identified as being promotion focused and an astonishing 131 participants identified as being indifferent. Given the unusually high number of indifferent responses, it was determined that a multiple linear regression analyses was to be conducted in order to further examine the data. In other words, this analysis allowed researchers to observe total scores of prevention and promotion, rather than attempting to separate participants into groups. Results of this analysis indicated that promotion scores were a significant predictor of ROM use within supervision, However, the results indicated that as the total promotion score decreased, regardless of prevention score, the more likely participants were to utilize ROM within supervision. According to Grant and Higgins (2013) individuals with higher promotion scores tend to work quickly, only plan for best case scenarios, feel dejected when things do not go as planned, are risk-takers, seek out positive feedback, and feel dejected without such feedback (Grant & Higgins, 2013). To state plainly, individuals with these characteristics may tend to seek out activities that are viewed as rewarding. Given these attributes and based on our findings, it would appear that supervisors with higher scores on the promotion scale may not view ROM systems

within supervision as a positive gain. In other words, supervisors with these higher scores may not view ROM system use within supervision as rewarding or helpful. Given the results, it would seem that as promotion scores decrease and individuals exhibit less of these characteristics, ROM use within supervision increases suggesting that individuals with lower promotion scores may view ROM use within supervision as more beneficial and rewarding than their high promotion score counterparts.

Training in ROM and ROM Use vs. Non-Use

A third hypothesis had been proposed, suggesting that supervisors who used ROM systems or received graduate/post graduate training in ROM systems would be more likely to use ROM within supervision. As predicted, results indicated that there was a significant difference in the use of ROM within supervision and those who had used outcome measures in their graduate clinical training, those who indicated that the use of outcome measures was an important part of their clinical training, those who had received any training on outcome measures, and those who indicated that outcome measures were a requirement at their current placement. These results are promising, given that the current literature states that that use of ROM systems and patient feedback has been shown to increase positive outcome while reducing deterioration rates (Hatfield & Ogles, 2006; Lambert et al., 2002; Shimokawa et al., 2010). These results suggest that those who are more familiar with ROM systems and have an increased understanding of them may be more likely to utilize them within the process of supervision.

Format of Supervision and ROM Use vs. Non-Use

Hypotheses four and five specifically sought to examine the relationship between the format of supervision and the use/non-use of ROM within the context of supervision.

As predicted, results suggested that the format of supervision (e.g. audio/video recording, case review, live supervision) did not influence the use of ROM use/non-use within supervision. An additional aspect to consider is that in addition to these results, many supervisors indicated that they did not frequently use recording as a way of identifying treatment non-responders. Given that it appears the use of recording is not used as frequently in supervision as is indicated by existing literature in addition to whether or not it influences the use of ROM, there seems to be very little reliance on external tools in order to identify non-responsive patients.

Furthermore, existing literature has suggested that the use of video recording may provide more effective supervision and psychotherapy training (Haggerty & Hilsenroth, 2011). Despite limited research within the field of supervision, most experts agree that the use of video/audio recording is an important component of the supervisory process. A review of the literature indicates that the use of video recording is "…(b) a medium to bring about changes in trainee self-perception, (c) a tool for enhanced self-analysis by trainees, (d) a way for supervisors to more accurately evaluate trainees, and (e) a way for trainees and supervisors to re-experience the therapy session" (Huhra, Yamokoski-Maynhart, & Prieto, 2008, p.412). In spite of literature suggesting that recording increases the effectiveness of supervision and is regarded as "best practice" (Goodyear & Bernard, 1998; Haggerty & Hilsenroth, 2011; Huhra et al., 2008) supervisors within the data set report that they, on average, are only using video/audio recording "sometimes" ($M = 2.34$). Taking the current results, in addition to the previously mentioned findings, continues to suggest that supervisors are not following supervisory "best practices" which may assist in the identification of patient's with a poor treatment response.

Demographics and ROM Use vs. Non-Use

A final hypothesis that was proposed, suggesting that demographic variables (age, gender, ethnicity, etc.) would have no statistically significant correlation with the use/lack of use of ROM systems. As predicted, there were no significant correlations found within any of the variables in relation to ROM use/non-use.

Integration of Open-ended Statements

The open-ended statement results provide additional information to the above findings in terms of how supervisors identify and respond to deteriorating/non-responsive patients as well as how they conceptualize the use of ROM systems within their supervisory practice. As mentioned in the previous sections, open-ended statement results pertaining to the use of clinical judgment (supervisor and supervisee) in the identification of treatment-non-responders were highly endorsed by participants (n = 142). This further indicates that supervisors are doing what is contraindicated by literature, which states that clinician judgment is an inadequate tool in identifying treatment non-responders (Hannan et al., 2005; Hatfield et al., 2010). Furthermore, only 41 responses indicated that they use tools (ROM systems) that are shown within the literature to be effective in identifying deteriorating/non-responsive patients, and even so, are used infrequently within supervision. Concerning still, is that few (n = 18) responses appeared to indicate that they relied on some form of verbal feedback from the patient, which has also been shown within the literature to be an effective indicator of deterioration (Shimokawa et al., 2010). While it is possible that these methods are used in conjunction with other empirically validated methods, it would still be expected that these methods would have higher endorsement given current research on their effectiveness.

Research conducted by Walfish and colleagues (2012) and Dexter (2017) have suggested that clinicians have a tendency to have an inflated view of self-assessment and a biased opinion of their efficaciousness in identifying deterioration and providing positive patient outcome. Based on this previous research, it is interesting to note that few responses (n = 18) indicated that supervisors rely on consultation for the identification of treatment non-responders. Moreover, only 32 responses indicated that they would encourage referral or consultation once non-responders had been identified. These results may play into Walfish's findings of self-assessment bias. In other words, it's possible that supervisors may have an inflated view of their skills, may rank themselves as better providers than their peers, and therefore may be less likely to encourage consultation or referral for their supervisee's patients.

The open-ended statement data also suggests that supervisors associate more weaknesses with the use of outcome measures than strengths, which may be an indicator of why so few supervisors appear to be utilizing them regularly within supervision. Furthermore, there may be significant misunderstandings about the utilization of ROM systems and misuse when they are being applied within supervision. Many of the open-ended statement responses indicated that they felt like ROM systems were an unreliable source of information. In other words, they believed that these systems "don't really measure anything that is meaningful" nor do they reflect accurate change within the patient. These beliefs conflict with current research within the field regarding the use of ROM systems (Hatfield & Ogles, 2006; Lambert et al., 2003; Probst et al., 2013, Reese et al., 2009; Simon et al., 2012; Whipple & Lambert, 2011). In actuality, monitoring patient progress has been accomplished by rationally derived or empirically derived algorithms

(i.e. ROM systems) which has been shown numerous times to be an effective method for identifying patients who may experience poor outcome (Hatfield & Ogles, 2007; Lambert et al., 2001) Additional studies examining ROM systems have since been conducted and further support these findings (Barkham et al., 2005; Knaup et al., 2009; Locke et al., 2011; Lueger, 2012; Reese et al., 2009; Shimokawa et al., 2010). These results are interesting, given that the majority of participants stated that they had received ROM training at some point in their clinical work. 80.7% of participants indicating that they used ROM systems in their graduate training, 82.3% stated that they had received ROM training at some point in their clinical work, 54.7% indicated that ROM was an important component of their clinical training and 60.22% reported that they use ROM in their current placement. It would seem, that despite training in clinical work, there is still a gap in understanding what ROM systems are designed to do. Potential reasons for this discrepancy could be there is a lack of understanding at the instructor/supervisor level, "training" may not be as thorough as would be needed in order to full understand ROM systems and their use, or perhaps participants do not view ROM systems as an important or necessary component of psychotherapy, supervision and training.

In addition to the above results from the open-ended statement data, few participants (n = 24) indicated that they used ROM systems to provide context to their clinical work. Furthermore, only seven participants reported that they would use ROM systems within supervision as a way to gage alteration of treatment. In a study by Hatfield and Ogles (2006), researchers investigated the influence of verbal patient feedback and formal ROM systems on clinical treatment decisions. Results suggested that psychologists felt that verbal patient feedback was more influential than information from

ROM systems on their clinical decisions, despite the data indicating that both forms of feedback had an equal impact on judgment. Interestingly, data from ROM systems suggesting patient deterioration actually led more psychologists to alter treatment, in comparison with verbal reports of deterioration from the patients. In other words, when ROM systems indicating patient deterioration was presented to clinicians, the chances of altering treatment were greatly increased (Hatfield & Ogles, 2006). Given that there appears to be a significant misunderstanding of the use of ROM among the participants, it makes sense that the current results do not match most of the existing supervision literature.

In addition to the above results, the open-ended statement data also revealed that supervisors were responding to non-responsive patients in a beneficial way by means of encouraging their supervisees to alter treatment planning, process this with the patient in session and re-visit basic techniques of psychotherapy. These responses are indicated by existing literature as methods and techniques that have a positive impact on patient outcome (Duncan et al., 2004; Orlinsky et al., 1994; Luborsky et al.,1983; Norcross & Wampold, 2011; Roehrle & Strouse, 2008; Whipple et al., 2003). While it is promising that supervisor's are encouraging interventions based on prior literature, it is still uncertain as to how effective these supervisors are at identifying all deteriorating and non-responsive patients. Furthermore, these supervisors may continue to rely on their own, or their supervisee's clinical judgment in order to determine treatment outcome, which may not fully capture therapeutic change. In other words, though supervisors may be encouraging changes within treatment in order to combat deterioration in some

patients, we cannot be sure that the changes within treatment are actually resulting in positive change.

Brief Summary of Findings

Due to the exploratory nature of the study, numerous variables were examined which resulted in mixed results. As a reference, statistically significant results of the aforementioned analyses and most prominent open-ended statement responses have been summarized below.

1. Supervisors appear to be utilizing methods that are contraindicated by existing literature (e.g. clinical judgment) in identifying non-responsive and deteriorating patients within the context of supervision. With supervisors frequenting the use of their own or their supervisee's clinical judgment in identifying treatment non-responders.
2. Supervisors appear to be more inclined to discuss treatment non-responders within supervision and have supervisees attend to the therapeutic relationship once non-responsive and deteriorating patients have been identified, which coincides to existing literature suggesting this has a positive impact on psychotherapy outcomes.
3. Supervisors are less likely to use tools (e.g. ROM systems) to identify these patients, though they have been shown in the literature to be effective at identifying treatment non-responders.
    a. Though ROM systems are more likely to be used when they are a requirement at the supervisor's primary placement, when they are used, they are used infrequently or irregularly

4. Despite training throughout clinical work, there appears to be a prominent lack of understanding of the purpose and use of ROM systems within supervision (Open-ended statements).
5. Supervisors who see a decrease in promotion score when the prevention score is held constant are more likely to use ROM systems within their supervision, suggesting that individuals with lower promotion scores may view ROM use within supervision as more rewarding and beneficial than those with higher promotion scores.

Chapter 7 Clinical and Research Implications

Clinical Implications

Current literature suggests that there is a pressing need to begin to implement the use of patient feedback into routine practice in order to monitor outcome and address deteriorating patients (Hatfield & Ogles, 2006; Lambert et al., 2003; Whipple & Lambert, 2011). The need to implement clinical tools to monitor outcome is supported by extensive research, which suggests that psychotherapists are unable to adequately identify deteriorating patients based on clinical judgment alone (Hatfield et al., 2010). Identifying and responding to deteriorating patients often requires a high level of self-awareness and reflective contemplation on part of the clinician (Bager-Charleson, 2010). It may be assumed that trainees who are new to clinical work may not possess this level of self-awareness at the start of their training, and may need to be guided by their supervisor in order to ensure the best possible outcome for their patients. Thus, supervisors may also need to experience higher levels of self-awareness and reflective contemplation in their work as both therapist and supervisor. This could potentially be accomplished by the use of ROM within the supervision of clinical practice.

One way to monitor outcome and identify patients who are at risk for deterioration is to implement the use of ROM systems within routine clinical training (Lambert et al., 2003). Furthermore, it would seem prudent to implement wide-spread training and use of ROM systems within the supervisory process in order to continually track patient progress among supervisees. As the current literature suggests that supervisors and trainees believe that supervision can and should impact patient outcome, there would appear to be a need to implement the use of formalized outcome assessment

in an effort to monitor patient change (Rast et al., 2017). The use of a formalized outcome assessment may help supervisors serve as the role of gatekeeper within clinical practice, protecting patients from the potential of inadequate care. In addition to this protective role, the use of ROM systems within supervision may help supervisors ensure the best possible outcome for their supervisee's patients.

Because there exists a plethora of research that suggests the use of ROM systems within treatment is significantly beneficial to improving treatment outcome, these findings may indicate that there is an increasing need to train practicing psychologists on how to use and maximize the benefits from the use of ROM systems (Lambert et al., 2001; Lambert & Hawkins, 2001; Lambert et al., 2001; Probst, Lambert, Dahlbender, Loew & Tritt, 2014; Whipple et al., 2003). The benefits of adding the use of ROM systems within the training process (e.g. supervision) would appear to be beneficial to both clinicians and patients in terms of maximizing the benefits of psychotherapy, both in routine clinical practice and within the training process.

Research Implications

In an effort to further the research of the use of ROM systems within supervision, it would seem prudent to identify what supervisors are currently doing within the process of supervision. Furthermore, it appears important to identify what characteristics supervisors' posses (e.g. Regulatory Focus) that may influence their use of ROM systems within supervision.

In a study conducted by Hatfield and Ogles (2007), researchers looked to examine the reasons why some clinicians used ROM systems while others did not. Using survey research, researchers surveyed random psychologists who were members of the APA

about their use of ROM systems within psychotherapy. Using the Practitioner Outcome Survey, clinicians were asked to answer questions related to outcome assessment within clinical use. Results indicated that practicing psychologists who used ROM systems were more likely to use the measures for treatment purposes and if their place of work required its use. Psychologists who did not use ROM systems cited concerns with the utility of the systems due to either issues with practicality or concerns that the use of the systems were not helpful in practice (Hatfield & Ogles, 2007).

Understanding what factors influence the use of ROM systems as well as what methods supervisors currently utilize to identify and address deteriorating patients would appear to be a crucial fist step towards implementing the use of ROM systems within the supervisory process. This research helps us understand current supervisory methods, supervisor's current understanding of the use of ROM systems within supervision, as well as gain further insight into best practices in monitoring patient outcome in the supervisory process. The results suggest that supervisors are currently using less than ideal methods for identifying treatment non-responders, and associate many weaknesses with ROM systems use, despite current literature indicating otherwise regarding their use. Based on these results, this research provides a stepping-stone in which to begin examining the methods of supervision currently being used by supervisors. Furthermore, this research opens the door for additional research to be conducted about how to best implement the use of ROM systems throughout supervision and the training of new clinicians within the field. An additional implication of this research is to directly study what supervisors are doing with their supervisees within supervision. Hatfield and Ogles (2006) have asked clinicians about patient progress and clinical treatment decisions.

Participants indicated that verbal reports from the patients were more influential within their clinical practice than ROM systems, though the use of ROM systems which indicated patient deterioration prompted more participants to alter treatment planning. This research, in addition to the current study, have asked clinicians twice about their methods in addressing patient deterioration. In lieu of this, it would seem that a next step within the research would be to directly observe supervisors in order to develop a deeper and more thorough understanding of current practices within supervision. Further recommendations are discussed in the following section.

Chapter 8 Recommendations

Supervision and Training

Current standards within the American Psychological Association have only incorporated supervision training within graduate training programs within the past several years (APA, 2006). Despite progress towards incorporating these practices into graduate work, current standards do not detail rigor, methods nor specific practices. In other words, it appears the current standards within graduate programs can range from current knowledge of supervisory methods obtained through coursework to supervision practicum opportunities for students. As one can see, training regarding supervision can span over a wide spectrum, with little regulation within APA graduate training programs.

Furthermore, there is no national standard as it pertains to licensure in clinical practice. Licensure procedures vary by state and degree type, and within these systems, additional requirements surrounding supervision may or not be present. For example, the state of Ohio requires licensed individuals who wish to become supervisors (Licensed Professional Clinical Counselor-Supervisor) to complete additional educational requirements pertaining to clinical supervision and pass an examination regarding clinical supervision, in addition to obtaining 1,500 additional clinical supervision hours (Laws and Rules, 2017). The state of Texas requires similar supervisor licensure requirements (Nate & Haddock, 2014). Other states, such as Alaska, do not require additional licensure to supervise, but do require a minimum of six hours of continuing education pertaining to clinical supervision in order to become a board approved professional counselor supervisor (Supervisor certification. section 08.29.210). Conversely, Connecticut, and Georgia do not require additional licensure to supervise, nor do these

states require continuing education credits pertaining to supervision or previous supervisory experience (Nate & Haddock, 2014). In other words, there is no consistency regarding requirements of potential supervisors on a national level.

Despite supervision not being considered a core competency within the field, there have been guidelines put into place in order to outline and define the essential practices of supervision (APA, 2014). This document, created by experts within the field of supervision, outlined 7 components of supervision in an attempt to address the deficiency in literature pertaining to "defining, assessing and evaluating supervisor competence" (APA, 2014, p. 4). The guidelines are organized into 7 domains, which include: 1) Supervisor Competence, 2) Diversity, 3) Supervisory Relationship, 4) Professionalism, 5) Assessment/Evaluation/Feedback, 6) Problems of Professional Competence, and 7) Ethical, Legal, and Regulatory Considerations (APA, 2014). The first domain appears to be the most notable in terms of how it pertains to the study at hand. It states:

> Supervisors strive to be competent in the psychological services provided to clients/patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take responsible steps to ensure the competence of their work and to protect others from harm (APA, 2014, p. 13).

Given this domain, it would seem prudent that supervisors are up to date on current literature, especially as it pertains to patient care. Given the current results of this study however, it would appear that supervisors are not utilizing current research regarding psychotherapy practices, nor are they implementing them with their

supervisory practices. This is shocking, given that the supervisor's primary responsibility is to ensure patient welfare by means of a positive outcome (Falender & Shafranske, 2004). As of now, there is currently little to no regulation regarding supervisory practices within the field. That being said, the APA is currently taking steps in order to implement supervision as a core competency in an effort to make supervision more evidenced-based and systemized within psychological training (APA, 2014). Given this shift, it would appear the incorporating additional training regarding the utilization of ROM and its usefulness within supervision would be an appropriate step.

It would seem that certain M.A/M.S and Social Work training programs and credentialing both experience a similar situation to that of the APA, despite being governed by separate organizations. As an example, the Counsel for Accreditation for Counseling and Related Educational Programs (CACREP) currently hold no requirement that students receive supervision training within their graduate work (CACREP, 2016). Unlike APA criteria which highlights guidelines for supervisor qualifications, CACREP standards highlights specific supervisor qualifications, which state:

> Site supervisors have (1) a minimum of a master's degree, preferably in counseling, or a related profession; (2) relevant certifications and/or licenses; (3) a minimum of two years of pertinent professional experience in the specialty area in which the student is enrolled; (4) knowledge of the program's expectations, requirements, and evaluation procedures for students; and (5) relevant training in counseling supervision (CACREP, 2016, p. 16).

While these qualifications are more specific than those outlined by the APA, there appears to several deficiencies within the guidelines. Firstly, it would seem that site

supervisors are not required to have a degree in counseling or be related to psychology, despite being preferred. Secondly, these qualifications do little to specify what "relevant certifications/licenses" are and lastly, it doe not specify what would constitute training within counseling supervision. While these qualifications would seem to be a good foundational point in which to further define and structure supervisory training, it remains a far cry from highly regulated supervisory practices. It should be noted however, individual states may have their own credentialing pertaining to supervisory practices, though these vary significantly from state to state and there is currently no national credentialing related to the practice of clinical supervision. Supervisory guidelines and training within the field of social work faces similar problems in their report regarding supervision standards. Namely, the standards of the field lack clarity as to training requirements and expectations. Furthermore, there is no distinction between clinical supervision and other forms of supervision within the field (e.g. Administrative, Educational, etc.) (NASW, 2013). Given the lack of specificity regarding clinical supervision, it would seem that the guidelines surrounding training within the field would lack clarity and exact requirements of what might be expected by those who practice.

Professional Practice

A quote by Anton Chekhov was featured at the beginning of the discussion portion of this paper, which read "Knowledge is of no value unless you put it into practice." While there have been significant strides in terms of creating a structure on which to base effective and beneficial supervisory practices (APA, 2014), there has yet to be any improvement in monitoring and implementing such practices. As mentioned previously, there are two fundamental goals of providing supervision: 1) Enhancing and

protecting patient welfare, and 2) facilitating the professional development of the supervisee (Falender & Shafranske, 2004). Previous research has shown that effective supervision is correlated with increased self-efficacy of the supervisee and increased supervisee autonomy (Gibson, Grey, & Hastings, 2009; Ladany, Mori, & Mehr, 2013). Despite the evidence of positive benefits on the supervisee as a result of effective supervision, supervisor impact on a supervisee's patients have been less clear (Ladany & Inman, 2012). In a study conducted by Rousmaniere and colleagues (2014), researchers explored supervisor impact on variance in patient outcome. Examining supervisors in a naturalistic training setting, researchers discovered that supervisors only account for .04% of variance within patients (Rousmaniere et al., 2014). Furthermore, the lack of variability was shown "across variables at the supervisor level—supervisor experience level, field (social work vs. psychology), and degree (M.S. vs. Ph.D.)—as well as the trainee level" (Rousmaniere et al., 2014, p.7). These results are notable, given that not only is ensuring patient outcome one of a supervisor's primary responsibilities, but also supervisors believe that they can and should have an impact on patient outcome (Falender & Shafranske, 2004; Rast et al., 2017).

Results of the current study appear to indicate that supervisors may be focused primarily on the professional and personal growth and development of supervisees, with less use of ROM to ensure a positive outcome for their supervisees' patients. This is discouraging, as not only should supervisors be monitoring patient outcome in order to address non-responsiveness to treatment, but also research has suggested that the inclusion of patient feedback within supervision is helpful to supervisees in assessing their clinical skills and allowing for improvement of those skills (Reese et al., 2009). In

other words, the use of ROM systems within supervision may help supervisors achieve both of their primary goals, and yet there appears to be little utilization of these tools within supervision. Additionally, within these findings, there appears to be significant misunderstanding on the use and benefit of ROM systems, which has been demonstrated within the existing literature (Hatfield & Ogles, 2006; Lambert et al., 2003; Probst et al., 2013, Reese et al., 2009; Simon et al, 2012; Whipple & Lambert, 2011). Given that supervisor competence is the first domain listed in the APA guidelines to supervisory practices, these results are concerning, as it may suggest supervisors are not aware, or perhaps even unwilling to acknowledge the existing literature surrounding ROM use in supervisory practices. Furthermore, the guidelines for clinical supervision in health psychology are listed as competencies to aspire to, and there is no specific structure or regulations regarding supervisory practices. Despite being aspirational in nature, there are also no current methods in place to effectively monitor the practice of supervision (APA, 2014). In light of the lack of regulation, one might ask the question: how effective and helpful are these guidelines in improving supervisory methods if supervisors are not actually putting them into practice?

Supervisor training. It would seem that given the current climate within the field, competency and continued development are currently based on independent supervisor's willingness to continually improve their practices. Given that there is no current way to monitor supervisory practices, it would appear that supervisors who wish to continually grow and develop their skills as supervisors of psychotherapy would need to begin implementing deliberate practice into their work. Different from routine performance, which is performing work as usual, deliberate practice is the act of

"repetitively practicing specific skills with continuous corrective feedback" in order to improve skill (Rousmaniere, Goodyear, Miller, & Wampold, 2017, p.9). As an example, Chow and colleagues surveyed a group of therapists in order to examine the amount of time and effort they devoted to deliberate practice. The results were astonishing, as their findings indicated that therapists who were considered to be highly effective in psychotherapy devoted four and half times the number of hours as less effective therapists to activities designed to improve their effectiveness (Chow et al., 2015). In other words, the more one dedicated time to behaviors specifically designed to increase effectiveness, the more effective they became. This is promising, given that current research states that therapist's effectiveness actually decreases over time (Goldberg et al., 2016). If this is the case, and the majority of psychotherapists become less effective overtime, it would seem crucial to begin implementing methods in order to halt or reverse the decline in therapist effectiveness. To put plainly, it would appear that through the act of engaging in deliberate practice, one could become a more effective therapist over time. Given this, it would also seem possible to become a more effective supervisor by engaging in deliberate practice behaviors pertaining to supervision. Furthermore, the supervisor modeling of deliberative practice behaviors may prove to be a helpful to supervisees as an aspect of clinical practice. One potential way of achieving this aim may be to begin implementing the use of ROM systems within the process of supervision.

Additional recommendations regarding supervisor training pertain to the regulatory focus results that were found within the study. As previously stated, there is no current way to monitor supervisory practices, and the effectiveness of supervision would seem to depend largely on supervisor willingness and dedication. Results indicated that

supervisors who had lower promotion scores, regardless of their score on prevention, are more likely to use ROM systems within supervision. It may be that supervisors who have a weaker promotion focus may be more likely to view the use of ROM systems within supervision as beneficial and rewarding. Individuals with lower promotion scores may take fewer risks, work more slowly than their high promotion score counterparts and plan for less than ideal situations in their work. ROM use within supervision by these individuals may be seen as more beneficial to their work and may play into more deliberative practice behaviors, which are modeled within the supervisory practice. As such, it may be beneficial to select supervisors who have fewer promotion oriented characteristics.

Supervisee training. As previously stated, one method of deliberative practice might be to begin implementing ROM systems into the supervisory process. With that, researchers within the field have already begun to outline various ways in which to incorporate the use of outcome measures within supervision, though given the current findings, these recommendations have appeared to go unnoticed. Swift and colleagues (2015) have recently proposed three different methods for integrating ROM systems into supervision for the benefit of supervisees:

> (1) training students to obtain and use objective client feedback, (2) using outcome monitoring to inform discussions of specific clients in supervision, and (3) using patterns of outcomes across clients to facilitate supervisee growth and development (p. 1).

These methods allow for implementation to occur at various stages within a supervisee's training, beginning first with a thorough understanding of ROM systems, their validity and reliability, the various types of systems and their use among different populations (Swift et al., 2015). Once this basic foundation has been set, supervisors could then go on to use specific patient feedback in order to guide the process of supervision. This would begin to foster supervisee growth, and encourage supervisees to begin integrating the objective feedback into their conceptualizations (Swift et al., 2015). The final method proposed by researchers suggests using overall patterns in patient feedback in order to guide supervision. As an example, supervisors may notice that supervisee patient outcomes follow a more positive trend with individuals with depression than with patients with anxiety. These patterns could then be incorporated in discussions within supervision, allowing the supervisee to reflect on why they may struggle with certain diagnoses, demographics, etc., which in turn may encourage supervisees to explore methods that would allow them to be more effective with these individuals (Swift et al., 2015). These suggestions for incorporating ROM systems into the supervision process are just the beginning stages of utilizing patient outcome monitoring within supervision. In addition to working towards implementing these systems into supervision, further research is needed in order to explore patient outcome and its relation to the use of ROM systems in supervision.

As previously stated, ROM systems have been shown to be effective and beneficial in identifying non-responsive and deteriorating patients within psychotherapy (Bambling et al., 2006; Lambert et al., 2001). As such, it should be included within the framework of evidenced-based practice and thus should be a training component both

within graduate work and the supervision process. Current standards set in the training of evidenced-based practices include workshops, the use of manuals and clinical supervision (Sholomskas, Sayracuse-Siewer, Rounsaville, Ball, & Nuro, 2005). Given that ROM systems are empirically based measures, it would seem prudent to incorporate them into clinical trainings and practices. As such, it would appear to be relatively simple to incorporate ROM systems training into supervisee training using the standard practices of evidenced-based practice training.

Patient education. An additional recommendation to incorporating the use of ROM systems within practice and supervision might be to begin educating patients on what they should seek out when engaging in psychological services. Given the vast amount of research that has shown the efficacy and effectiveness of ROM systems within psychotherapy, patients should be informed that the use of ROM is a method their therapist should be implementing within their treatment. Furthermore, given that the APA has issued a statement which indicated that treatment should not be based upon diagnosis, theoretical orientation of the therapist and providing brand name treatments is less critical to ensuring positive outcome than monitoring outcome and making alterations to treatment as needed based on patient progress (APA, 2012). In lieu of this, this researcher proposes that therapists should be educating their patients as to the purpose of ROM systems. Furthermore, supervisors should be encouraging their supervisees to have transparent discussions with their patients regarding the use of ROM systems within treatment.

Chapter 9 Limitations

As with most research, there are limitations that are associated with this study. Many of these limitations have been recorded throughout this document, however general limitations associated with this study's design still need to be addressed. There are multiple limitations within this study that are often associated with a non-standardized, self-report survey. The two most common limitations associated with method of research are the under-reporting of negative behaviors and responding to questions that portray responders in a positive light (Donaldson & Grant-Vallone, 2002). As previously mentioned, supervisors who completed this survey may be pulled to portray their methods of identifying deteriorating patients in a more positive light (e.g. over-report the use of ROM systems) and under-reporting negative behaviors such as not monitoring deteriorating patients at all. Walfish and colleagues (2012) found that self-assessment bias, which as an overly positive assessment of personal accomplishments, to be present among practicing psychotherapists. Within the study, researchers found that clinicians tended to overestimate the rates of patient improvement while underestimating the rates of patient deterioration (Walfish et al., 2012). Furthermore, supervisors may fall victim to this 'Lake Woebegone Effect,' in which they may overstate their accomplishments, regardless of where they actually fall on the natural distribution (Maxwell & Lopus, 1994).

It should also be noted that survey research is generally uncompromising once it has been distributed (Singleton & Strait, 2010). In other words, there was little to be done regarding misunderstanding or confusion regarding the survey once it had been distributed to participants. Additionally, survey research is also associated with low-

response rates and non-response bias, where individuals who complete the survey may not accurately represent the population as a whole (Gravetter & Foranzo, 2012). Furthermore, while every effort has been made to include a culturally diverse sample, minority populations are often underrepresented within the field of psychology, which may make generalizing these results to minority populations inappropriate (Henrich, Heine, & Norenzayan, 2010).

An additional limitation of non-standardized, self-report survey research is that may focus too broadly on the topic at hand, resulting in lack of depth and preventing a full understanding of the research area. The open-ended statement portion of this study was designed with this limitation in mind, and served to add depth to the survey portion. However it should be noted that there is currently no existing literature addressing the practices of supervisors on identifying and addressing deteriorating patients within supervision, nor research regarding supervisors and the influence of regulatory focus. With that, this limitation was deemed necessary in expanding this topic area so that more in-depth analyses may be conducted at a later time. It should also be noted that these findings are limited to the population sample. Due to this, these results may lack significantly in terms of cultural diversity. As previously mentioned, minority populations have historically been underrepresented within the discipline of psychology, and continue to be underrepresented within the field (Henrich et al., 2010). While every effort was attempted to include a culturally diverse sample, these results are based on a largely White, Westernized perspective. As such, it would be inappropriate to generalize these findings to minority populations within the field. A final limitation of significance to discuss is that this study utilized a non-experimental design. In other words, this study

was not designed to illuminate the relationships between the variable, but rather reveal the strength of their associations (Singleton & Strait, 2010). It should be noted that this limitation was expected due to this study's exploratory nature.

Chapter 10 Future Directions

As noted earlier within the document, this study served as an exploratory examination of the methods of practicing supervisors in identifying and responding to deteriorating and non-responsive patients. Additionally, this author sought to explore the use of ROM systems within this process and the influence of regulatory focus in the use of these systems. While suggestions for future research have been included throughout the document, the following suggestions aim to extend these recommendations and implications in an effort to contribute to the field of psychotherapy supervision. As previously stated, specific recommendations regarding the results of this study include increased supervisor training regarding ROM systems use, implementing ROM within supervision by way of training students in their use, using ROM systems to inform discussions and using patterns in outcome to facilitate supervisee growth. Additionally, supervisors modeling deliberative practices for supervisees in regard to its clinical use may also prove to be helpful. Lastly, educating patients on the purpose and usefulness of ROM systems and encouraging supervisees to have transparent conversations with their patients regarding the use of ROM systems may be helpful in the implementation of their use.

As such, further research could begin by examining graduate training programs, focusing on the training requirements surrounding supervision in addition to the level of training that students are receiving on ROM systems within their clinical training. This would help researchers establish a baseline regarding thoroughness of training, which would in turn be a jumping off point for establishing regulations around supervision in all degree levels (Ph.D./Psy.D, M.A/M.S/M.S.W). In addition, future research regarding

supervisory methods may help researchers further understand how supervisors are incorporating ROM use into supervision. Future studies may also seek to look at supervision training and credentialing for licensure, supervision requirements and additional licensure requirements for supervisors in order to determine what practices are currently in place and to explore potential improvements to the existing standards.

Given that there is limited research on supervisory practices pertaining to the general population, there is also little to no research regarding supervisory practices and ROM use with minority populations. The use of outcome measures with patients who identify as a minority may vary from the general population, and would thus, impact their use in supervision. Further research may be beneficial in identifying supervisory practices within this population, as well as explore any differences in ROM use with minority populations in comparison with the general population. Furthermore, in addition to the aforementioned potential studies, future research may also seek to explore supervisory practices in rural areas in an effort to explore whether significant differences exist between rural methods of supervision and those of general standard practices in an effort to better monitor practices and care for rural populations.

Chapter 11 Conclusion

Supervision is a crucial and important component of psychotherapy training. At this end, supervisors should aspire to not only contribute to the professional growth and development of their supervisee, but also work towards ensuring patient progress by way of positive outcome. This study aimed to examine what methods supervisors were currently using to identify and work with deteriorating patients within supervision. This examination was conducted by first examining how supervisors identify treatment non-responders, exploring what methods supervisors use in order to address deteriorating and non-responsive patients and whether or not regulatory focus impacted the use of ROM systems within supervision. The results indicated that fortunately, many supervisors work tirelessly in order to ensure the professional and personal progress of the supervisee. Unfortunately, the monitoring of patient progress does not seem to be met with the same enthusiasm. Despite increasing literature that states that routine outcome monitoring is an effective and valuable tool of monitoring patient outcome, supervisors appear to be unwilling to fully incorporate them into their supervisory practices. Instead, these supervisors appear to rely on ineffective methods, such as clinical judgment, in order to identify non-responsive and deteriorating patients. Research has continuously suggested that clinical judgment, as a stand alone method of identifying treatment non-responders is inefficient. To that end, it remains important that supervisors continue to seek out additional tools in which to monitor patient progress and incorporate them into routine procedure by way of deliberate practice. In order to achieve this goal, graduate training and licensing entities should seek to set structured and specific guidelines in which to regulate supervisory practices. As of now however, it would appear that supervisors

continue to practice outside of the research evidenced methods, potentially missing opportunities to identify and address deteriorating and non-responsive patients within the context of supervision.

References

American Psychological Association [APA]. (2006) Evidenced based practice in psychology. *American Psychologist*, *61*(4), 271-285.

American Psychological Association [APA]. (2014). Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from: http://apa.org/about/policy/guidelines-supervision.pdf

American Psychological Association [APA]. (2006). Guidelines and Principles for Accreditation of Programs in Professional Psychology (G&P). Retrieved from http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf

American Psychological Association [APA]. (2012) Recognition of psychotherapy effectiveness. *American Psychological Association.*

Asun, R. A., Rdz-Navarro, K., & Alvarado, J. M. (2016). Developing multidimensional Likert scales using item factor analysis: The case of four-point items. *Sociological Methods and Research*, *45*(1), 109-133.

Atwood, G. E. & Stolorow, R. D. (1993). *Faces in a cloud*. Northvale, NJ: Jason Aronson, Inc.

Bager-Charleson, S. (2010). *Reflective practice in counseling and psychotherapy*. Exeter, UK: Learning Matters.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*, 317-331. doi:10.1080/10503300500268524

Barkham, M., Gilbert, N., Connell, J., Marshall, C., & Twigg, E. (2005). Suitability and utility of the CORE-OM and CORE-A for assessing severity of presenting problems in psychological therapy services in primary and secondary care settings. *The British Journal of Psychiatry*, *186*, 239-246.

Bazeley, P. (2013). *Qualitative Data Analysis Practical Strategies*. London: Sage Publications.

Benjamin, Y., & Hochberg, Y. (1995) Controlling for false discovery rate: A practical and powerful approach to multiple testing. *Journal of the Royal Statistical Society, 57*(1) 289-300.

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of Clinical Supervision (5th ed.).* Needham Heights, MA: Allyn & Bacon

Campbell, A., & Hemsley, S. (2009). Outcome rating scale and session rating scale in psychological practice: Clinical utility of ultra-brief measures. *Clinical Psychologist,13*(1), 1-9.

Cheon, H.., Blumer, M.L.C., Shih, A., Murphy, M.J., Sato, M. (2009). The influence of supervisor and supervisee matching, role conflict, and supervisory relationship on supervisee satisfaction. *Contemporary Family Therapy, 31*, 52-67.

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. Psychotherapy, *52*, 337–345.

Counsel for Accreditation for Counseling and Related Educational Programs [CACREP] (2016). 2016 CACREP Standards. Retrieved from: http://www.cacrep.org/wp-content/uploads/2017/07/2016-Standards-with-Glossary-7.2017.pdf

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). London, UK: Sage.

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*(2), 155-159.

De Jong, K., & De Goede, M. (2015). Why do some therapists not deal with outcome monitoring feedback? A feasibility study on the effect of regulatory focus and person-organization fit on attitude and outcome. *Psychotherapy Research*, *25*(6), 661-668.

Dexter, K. (2017). Routine outcome monitoring and clinical supervision. Do therapists really care about their patients? (Unpublished doctoral dissertation). University of Alaska, Fairbanks. Fairbanks, AK.

Donaldson, S. I., & Grant-Vallone, E. J. (2002). Understanding self-report bias in organizational behavior research. *Journal of Business & Psychology*, *17*(2), 245-260.

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2004). The session rating scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy*, *3*(1), 3-12.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins (Ed.), *Handbook of Psychotherapy Supervision* (pp. 447–507). New York: Wiley.

Evans, Chris, Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. British Journal of Psychiatry, 180(JAN.), 51-60.

Evans, Chris, Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health, 9*, 247-255.

Falender, C. A., Erickson Cornish, J. A., Goodyear, R., Hatcher, R., Kaslow, N. J., Leventhal,G., . . . Sigmon, S. T. (2004). Defining competencies in psychology supervision: A consensus statement. *Journal of Clinical Psychology*, *60*(7), 771-785.

Falender, C. A., & Shafranske, E. P. (2004). *Clinical Supervision: a Competency-Based Approach.* Washington, DC: APA Press.

Fellner, B., Holler, N., Kirchler, E., & Schabmann, A. (2007). Regulatory focus scale (RFS): Development of a scale to record dispositional regulatory focus. *Swiss Journal of Psychology*, *66*(2), 109-116.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, *3*(1), 6-25.

Fireman, G. D. (2002). Approaching accountability in psychotherapy. *Journal of Constructivist Psychology*, *15*(3), 219-231.

Gibson, J. A., Grey, I .M., & Hastings, R. P. (2009). Supervisor support as a predictor of burnout and therapeutic self-efficacy in therapists working in ABA schools. Journal of Autism and Developmental Disorders, 39,1024–1030.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielson, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology*, *63*(1), 1-11.

Goodyear, R. K., & Bernard, J. M. (1998). Clinical supervision: Lessons from the literature. *Counselor Education and Supervision*, *38*(1), 6-22.

Gosling, S. D., Vazire, S., Srivastava, S., & John, O. P. (2004). Should we trust web-based studies? *American Psychologist*, *59*(2), 93-104.

Grant, H., & Higgins, E.T. (2013). Do you play to win-or not to lose? *Harvard Business Review, 91*(3), 117-120.

Gravetter, F. J., & Forzano, L.-A. B. (2012). *Research methods for the behavioral sciences* (4th ed.). Belmont, CA: Wadsworth.

Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains. *Journal of Clinical Psychology*, *58*(9), 1157-1172.

Haggerty, G., & Hilsenroth, M. J. (2011). The use of video in psychotherapy supervision. *British Journal Of Psychotherapy*, *27*(2), 193-210. doi:10.1111/j.1752-0118.2011.01232.x

Hannan, C., Lambert, M. J., Harmon, C., Nielson, S. L., Smart, D. W., & Shimokawa, K. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, *61*(2), 155-163.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*, *9*(3), 329-343.

Hatfield, D., McCullogh, L., Frantz, S. H., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology and Psychotherapy*, *17*(1), 25-32.

Hatfield, D. R., & Ogles, B. M. (2006). The influence of outcome measures in assessing client change and treatment decisions. *Journal of Clinical Psychology*, *63*(3), 325-337.

Hatfield, D. R., & Ogles, B. M. (2007). Why some clinicians use outcome measures and others do not. *Administration Policy in Mental Health and Mental Health Services Research*, *34*, 283-291.

Hellevik, O. (2009) Linear versus logistic regression when the dependent variable is a dichotomy. *Quality & Quantity, 43*(1), 59–74. http://doi.org/10.1007/s11135007-90773

Henrich, J., Heine, S., & Norenzayan, A. (2010). The weirdest people in the world. *Behavioral and Brain Sciences*, *33*(2), 1-75.

Hess, A. K., Hess, K. D., & Hess, T. H. (Eds.). (2008). *Psychotherapy supervision: Theory, research and practice* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Higgins, E.T. (1997). Beyond pleasure and pain. *American Psychologist, 52*, 1280-1300

Higgins, E.T. (1998). Promotion and prevention: Regulatory focus as a motivational principle. *Advances in Experimental Social Psychology, 30,* 1-46.

Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight, and action*. Washington, DC: APA Books.

Hofmann, S. G., & Barlow, D. H. (2014). Evidence-based psychological interventions and the common factors approach: The beginnings of a rapprochement?. *Psychotherapy*, *51*(4), 510-513.

Hoffman, M., Hill, C. E., Holmes, S. E., & Freitas, G. F. (2005). Supervisor perspective on the process and outcome of giving easy, difficult, or no feedback to supervisees. *Journal of Counseling Psychology*, *52*(1), 3-13.

Huhra, R. L., Yamokokski-Maynhart, C. A., & Prieto, L. R. (2008). Reviewing videotape in supervision: A developmental approach. *Journal of Counseling & Development*, *86*(4), 412-418.

Kilminster, S. M., & Jolly, B. C. (2000). Effective supervision in clinical practice settings: A literature review. *Medical Education*, *34*, 827-840.

Knaup, C., Koesters, M., Schoefer, D., Becker, T., & Puschner, B. (2009). Effect of feedback of treatment outcome in specialist mental health care: Meta-analysis. *The British Journal of Psychiatry*, *195*, 15-22.

Krosnick, J. A. (1999). Survey research. *Annual Review of Psychology*, *50*, 37-67.

Ladany, N., & Inman, A. G. (2012). Training and supervision. In E. Altmaier & J. C. Hansen (Eds.), Oxford handbook of counseling psychology (pp. 179 –207). New York, NY: Oxford University Press.

Ladany, N., Mori, Y., & Mehr, K. E. (2013). Effective and ineffective supervision. The Counseling Psychologist, 41, 28-47. doi.org/10.1177/0011000012442648

Lambert, M.J., Burlingame, G.M., Umphress, V., Hansen, N.B., Vermeersch, D.A., Clouse, G.C., & Yanchar, S.C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*(4), 249-258.

Lambert, M.J., Hansen, N.B., & Finch, A.E. (2001). Client-focused research: Using client outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*(2), 159-172.

Lambert, M. J., Hansen, N. B., & Harmon, S. C. (2010). Outcome Questionnaire System (The OQ system): Development and practical applications in healthcare settings. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies* (pp. 141-154). Chichester, UK: Wiley & Sons.

Lambert, M. J., & Hawkins, E. J. (2001). Using information about patient progress in supervision: Are outcomes enhanced? *Australian Psychologist*, *36*, 131–138.

Lambert, M.J., Morton, J.J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R.C., et al. (2004). Administration and scoring manual for the Outcome Questionnaire 45. Salt Lake City, UT: OQ Measures L.L.C.

Lambert, M.J., & Ogles, B.M. (1997). The effectiveness of psychotherapy supervision. C.E. Watkins, Jr., (Ed.). *Handbook of psychotherapy supervision.* 421-446. New York: Wiley

Lambert, M. J., & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed., pp. 139-193) New York: Wiley

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, *48*(1), 72-79.

Lambert, M. J., Whipple, J. L., Bishop, M. J., Vermeersch, D. A., Gray, G. V., & Finch, A. E. (2002). Comparison of empirically-derived and rationally-derived methods for identifying patients at risk for treatment failure. *Clinical Psychology and Psychotherapy*, *9*, 149-164.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielson, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology Science and Practice*, *10*(3), 288-301.

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, *11*(1), 49-68.

Laws and Rules. (2017) Ohio Laws 7-242 (Ohio Counselor, Social Worker & Marriage and Family Therapist Board Sept. 1, 2017).

Levine, J.C., Cruz, R.A., Cooper, L.D., Murphy, H.G., Peterson, A.P., Hurd, L.E., & Feldner, M.T. (2017). Integrating routine outcome monitoring into graduate training clinics to advance evidence-based practice. *The Behavior Therapist,* 17-22

Locke, B. D., Buzolitz, J. S., Lei, P., Boswell, J. F., McAleavey, A. A., Sevig, T. D., & ... Hayes, J. A. (2011). Development of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62). *Journal of Counseling Psychology*, *58*(1), 97-109.

Locke, B. D., McAleavey, A. A., Zhao, Y., Lei, P., Hayes, J. A., Castonguay, L. G., & ... Lin, Y. (2012). Development and initial validation of the Counseling Center Assessment of Psychological Symptoms–34. *Measurement & Evaluation In Counseling & Development (Sage Publications Inc.)*, *45*(3), 151-169.

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy, a counting signs vs. a global rating method. Journal of Nervous and Mental Disorder, 171(8), 480 – 491.

Lueger, R. J. (2012). The Integra/COMPASS Assessment Tracking System. *Integrating Science and Practice*, *2*(2).

Maxwell, N. L., & Lopus, J. S. (1994). The Lake Woebegone effect in student self-reported data. *The American Economic Review*, *84*(2), 201–205.

McAleavey, A. A., Nordberg, S. S., Hayes, J. A., Castonguay, L. G., Locke, B. D., & Lockard, A. J. (2012). Clinical validity of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62): Further evaluation and clinical applications. *Journal of Counseling Psychology*, *59*(4), 575-590.

Miller, S. D., & Duncan, B. L. (2000). The Outcome Rating Scale. Chicago: Author.

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, *2*(2), 91-100.

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2004). The partners for change outcome management system. *Journal of Clinical Psychology*, *61*, 1-10.

Milne, D. L. (2009). *Evidence based clinical supervision: Principles and practice*. Maldin, MA: Wiley

Milne, D. L., Sheikh, A. I., Pattison, S., & Wilkinson, A. (2011). Evidence-based training for clinical supervisors: A systematic review of 11 controlled studies. The Clinical Supervisor, 30(1), 53-71. doi: 10.1080/07325223.2011.564955

Minami, T., Davies, D. R., Tierney, S. C., Bettmann, J. E., McAward, S. M., Averill, L. A., Huebner, L. A., Weitzman, L. M., Benbrook, A. R., Serlin, R. C., & Wampold, B. E. (2009). Preliminary evidence on the effectiveness of psychological treatments delivered at a university counseling center. *Journal of Counseling Psychology, 56*, 309-320.

Minami, T., Serlin, R. C., Wampold, B. E., Kircher, J. C., & Brown, G. S. (2008). Using clinical trials to benchmark effects produced in clinical practice. *Quality and Quantity, 42*, 513-525.

Minami, T., Wampold, B. E., Serlin, R. C., Kircher, J. C., & Brown, G. S. J. (2007). Benchmarks for psychotherapy efficacy in adult major depression. *Journal of Consulting and Clinical Psychology, 75*, 232–243

Nate, R.D., & Haddock, L.R., (2014). An exploration of counselor supervisor requirements across the United States. *Vistas,31,* 1-14

National Association of Social Workers [NASW]. (2013). Best practice standards in social work supervision. Retrieved from: http://www.naswdc.org/practice/naswstandards/supervisionstandards2013.pdf

Nelson, M.L., Barnes, K.L., Evans, A.L., Triggiano, P.J. (2008). Working with conflict in clinical supervision: Wise supervisor perspectives. *Journal of Counseling Psychology, 55*, (2), 172-184.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, *48*(1), 4-8.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, *48*(1), 98-102.

O'Donovan, A., Halford, K., & Walters, B. (2011). Towards best practice supervision of clinical psychology trainees. *Australian Psychologist*, *46*(2), 101–112.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—Noch einmal. In A. E. Bergen, & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change (pp. 270 – 376). New York: Wiley

Pagano, R. R. (2001). *Understanding statistics in the behavioral sciences* (6th ed.). Belmont, CA: Wadsworth.

Pearson, Q.M. (2001). A case in clinical supervision: A framework for putting theory into practice. *Journal of Mental Health Counseling, 23*(2), 174-183.

Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *The American Journal of Psychiatry*, *159*(9), 1312-1321.

Probst, T., Lambert, M. J., Dahlbender, R. W., Loew, T. H., & Tritt, K. (2014). Providing patient progress feedback and clinical support tools to therapists: Is the therapeutic process of patients on-track to recovery enhanced in psychosomatic in-patient therapy under the conditions of routine practice? *Journal of Psychosomatic Research*, *76*, 477-484.

Probst, T., Lambert, M. J., Loew, T. H., Dahlbender, R. W., Gollner, R., & Tritt, K. (2013). Feedback on patient progress and clinical support tools for therapists: Improved outcome for patients at risk of treatment failure in psychosomatic in-patient therapy under the conditions of routine practice. *Journal of Psychosomatic Research*, *75*, 255-261.

Rast, K.A., Herman, D.J., Rousmaniere, T.G., Swift, J., & Whipple, J. (2017). Supervisor effects on client outcomes: Practicing supervisors' and supervisees' perspectives. *Sage Open*.

Reese, R.J., González, E.G., Clements-Hickman, A.L., Clemons, J.M., Farook, M.W., & Conoley, C.W. (2017): The psychotherapy researcher–practice relationship: Through a clinical supervision lens, Counseling Psychology Quarterly, doi: 10.1080/09515070.2017.1285270

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy Theory, Research, Practice, Training*, *46*(4), 418-431.

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, *3*, 157–168. doi:10.1037/a0015673

Roehrle, B., & Strouse, J. (2008). Influence of social support on success of therapeutic interventions: A meta-analytic review. *Psychotherapy Theory, Research, Practice and Training*, *45*(4), 464-476.

Rousmaniere, T.G., Goodyear, R., Miller, S.D., & Wampold, B.E. (2017). The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training. London: Wiley Publishers.

Rousmaniere, T.G., Swift, J.K., Babins-Wagner, R., Whipple, J.L., & Berzins, S. (2014): Supervisor variance in psychotherapy outcome in routine practice, Psychotherapy Research, doi: 10.1080/10503307.2014.963730

Seligman, M. E. (1995). The effectiveness of psychotherapy. *American Psychologist*, *50*(12), 965-974.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology*, *78*(3), 298-311.

Sholomskas, D.E., Syracuse-Siewert, G., Rounsaville, B.J., Ball, S.A., & Nuro, K.F. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology*. 73:106–115.

Simon, W., Lambert, M. J., Harris, M. W., Busath, G., & Vazquez, A. (2012). Providing patient progress information and clinical support tools to therapists: Effects on patients at risk of treatment failure. *Psychotherapy Research*, *22*(6), 638-647.

Singleton, Jr, R. A., & Strait, B. C. (2010). *Approaches to social research* (5th ed.). New York, NY: Oxford University Press.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*, 752-760.

Stedmon, J., & Dallos, R. (Eds.). (2009). *Reflective practice in psychotherapy and counselling*. Berkshire, England: Open University Press.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: A counselor complexity model. *Journal of Counseling Psychology*, *28*(1), 59-65.

Supervisor certification, AK. Stat. § 08.29.210 (2017).

Swift, J. K., Callahan, J. L., Rousmaniere, T. G., Whipple, J. L., Dexter, K., & Wrape, E. R. (2015). Using client outcome monitoring as a tool for supervision. *Psychotherapy*, *52* (2), 180-184.

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnosis systems should be abolished. *International Journal of Clinical and Health Psychology, 14,* (3), 208-215.

Vermeersch, D.A., Lambert, M.J., & Burlingame, G.M. (2000). Outcome Questionnaire: Item sensitivity to change. *Journal of Personality Assessment, 74*(2), 242-261.

Von Hippel, P. (2015, July 5). Linear vs. logistic probability models: Which is better, and when? Retrieved January 13, 2018, from https://statisticalhorizons.com/linear-vs-logistic

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, *110*(2), 639-644.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin*, *122*(3), 203-215.

Ward, C. C., & House, R. M. (1998). Counseling supervision: A reflective model. *Counseling Supervision*, *38*(1), 23-33.

Warner, R. M. (2013). *Applied statistics from bivariate through multivariate techniques* (2nd ed.). Thousand Oaks, CA: Sage.

Watkins, E. C. (Ed.). (1997). *Handbook of psychotherapy supervision*. New York City, NY: John Wiley & Sons.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research*, *7*(1), 54-65.

Whipple, J. L., & Lambert, M. J. (2011). Outcome measures for practice. *Annual Review of Clinical Psychology*, *7*, 87-111.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment failure and problem-solving strategies in routine practice. *Journal of Counseling Psychology*, *50*(1), 59-68.

Worthen, V. E. & Lambert, M. J. (2007). Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. Counseling and Psychotherapy Research, *7*(1), 48-53.

Wright, K. B. (2005). Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication*, *10*(3).

Yates, D., Moore, Moore, D., McCabe, G. (1999). *The Practice of Statistics* (1st Ed.). New York: W.H. Freeman.